# Doctoral Thesis

God in times of adversity: A mixed-methods study investigating the relationship between religious coping and identification on the trauma appraisals and world assumptions of Muslim refugees/asylum seekers.

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# Abstract

**Background**: The Cognitive Model of PTSD highlights the importance of pre-trauma beliefs on trauma appraisals and coping mechanisms. Worldview-based models propose that traumas shatter fundamental world assumptions, resulting in a search for meaning. Religion provides one way of offering meaning for individuals during times of distress. This research aimed to link Religious Coping Theory with cognitive and worldview-based trauma models to investigate the role of religious coping and identification on world assumptions and trauma appraisals within a community sample of Muslim refugees/asylum seekers.

**Method**: A sequential mixed-methods design was used. Quantitative questionnaires were initially administered to eighty four participants, followed by qualitative interviews with six participants.

**Results**: Quantitative findings indicate that religious coping and identification did not explain substantial variance in trauma symptoms, appraisals and world assumptions. Exploratory analyses revealed significant correlations between questionnaire language and trauma symptoms as well as immigration status, trauma appraisals and world assumptions. Qualitative findings, in contrast, illustrate the significant influence of Islam on the trauma appraisals, world assumptions and coping mechanisms of participants. Islam seemed to be used to evaluate and deal with trauma experience within premigration, migration and post-migration phases of the refugee/asylum seeker journey.

**Conclusion**: These findings illustrate the need for greater research on cultural explanatory models of trauma for this population. This study provides specific insight into how participants utilise Islam in appraising and coping with their trauma experiences through the various phases of their journey. Findings are discussed in light of limitations, research and clinical implications.

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# Acknowledgements

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# 1. Introduction and context

Today's society witnesses one of the worst forced global displacement crises. This has resulted in the displacement of 65.6 million people, with over 22.5 million refugees (UNHCR, 2017). The unrest in the Middle-East and Africa, particularly following the Arab Spring in 2010 and the continued political conflict, has resulted in the mass movement of people (Fargues & Fandrich, 2012). This has contributed to Europe's worst refugee crisis since World War II (World Economic Forum, 2017). In 2016, within the UK, asylum seekers made up 6% of the migrant population, with 52% of asylum applicants coming from Middle Eastern, and North Sub-Sharan African regions (Hawkins, 2018).

The UK is under the obligations of the Refugee Convention (1951; 1967). Accordingly, an asylum seeker is someone who has crossed international borders pursuing protection due to persecution or war. Article 3 of the Refugee Convention (1951), prevents the deportation of an individual back to a country where they may be subjected to torture or inhuman treatment. Within the UK, refugees are those who have been acknowledged by the Home Office and provided protection (Home Office, 2017). This recognition provides individuals with 'leave to remain', allowing them to legally stay in the UK for five years, after which, the individual can apply for a more permanent status of 'Indefinite Leave to Remain'.

This crisis arises at a time where the threat of terrorism has led to a deterioration in the essence of the UN Refugee Convention, giving rise to anti-immigration policies across Europe (Esses, Hamilton, & Gaucher, 2017). This has made migration and post-migration experiences challenging for this population. Given the multiple trauma experiences refugees face, the scope for psychological research and intervention is not only immense but integral to their sense of well-being.

Exposure to trauma can result in the development of Post-Traumatic Stress Disorder (PTSD; Friedman, Keane, & Resick, 2007). One factor shown to influence PTSD

development and maintenance is cognitive appraisals, the subjective meaning-making process, which is particularly important to clinical cognitive models of PTSD (Kleim et al. 2007). The Cognitive Model of PTSD (Ehlers & Clark, 2000) especially highlights the significance of cognitive appraisals of trauma (trauma appraisals) and their purpose in a continued sense of current threat to a survivor's life. This is facilitated by the use of unhealthy coping strategies, resulting in maintaining symptoms. These appraisals are possibly modifiable. Consequently, they form significant targets for treatments (Resick, 2001). Research also indicates that cognitive factors are the most valuable pre-trauma and trauma-specific characteristics and predictors for identifying chronic PTSD (Kleim et al. 2007). Therefore, trauma appraisals and cognitive coping mechanisms are said to play an integral role in the development, maintenance and treatment of PTSD (Conway & Jobson, 2012; Engelbrecht & Jobson, 2014; Jobson & O'Kearney, 2009). Such findings underlie the cognitive focus of this study.

Traumas are said to shatter people's existing fundamental assumptions about the world (world assumptions), which can create a search for a renewed sense of meaning (Janoff-Bulman, 1992; Kreitler & Kreitler, 1988). Religion may demonstrate one method of providing meaning during periods of distress (Baumeister, 2005; Pargament, 1997). Accordingly, religion could be associated with post-trauma adjustment for trauma survivors like refugees/ asylum seekers.

Religion has received growing interest within the social sciences over the past two decades, particularly as a coping method for distress (Braam et al., 2010). Research, however, has been centred around Christian traditions, with limited focus on religious traditions like Islam (Abu-Raiya & Pargament, 2011, 2014). Furthermore, despite the acknowledgement of PTSD as a universal phenomenon (Figueira et al., 2007; Jobson, 2009), present understandings appear largely Eurocentric, with inadequate knowledge about the aetiology,

maintenance and treatment of PTSD for individuals from non-Western cultures (Figueira et al., 2007; Foa, Keane, Friedman, & Cohen, 2009). This is particularly important given the current context, with the majority of refugees coming from largely Muslim regions (Hawkins, 2018).

The importance of acknowledging socio-cultural ways of dealing with distress and wellbeing is acknowledged within Psychology (Fernando, 2014; Tribe, 2014). A core value of Counselling Psychology is social justice, with the aim of promoting health through increasing accessibility, equality and ideal developmental prospects for all individuals (Kennedy & Arthur, 2014). Furthermore, professional guidelines highlight that Psychologists must "adapt practice to meet the needs of different groups and individuals" (HCPC, 2016, p.8). Consequently, it becomes important to understand factors that may promote and make healthcare more accessible for this population (Patel, Tribe & Yule, 2018).

## 1.1. Research Scope

This research aims to understand the role of religious coping and identification on the world assumptions and trauma appraisals of Muslim refugees/ asylum seekers using a mixed-methods approach. Specifically, using Pargament's (1997) Religious Coping Theory, this study examines how Islam impacts the manner in which Muslim refugees/asylum seekers make sense of, interpret and cope with trauma experiences. The study also examines the impact of religious identification, the acceptance of beliefs as personal values (Ryan et al., 1993), on world assumptions and trauma appraisals of Muslim refugees/asylum seekers. Furthermore, it seeks to link Religious Coping Theory with the Cognitive Model of PTSD (Ehlers & Clark, 2000) and worldview-based trauma models (Janoff-Bulman, 1992; Pyszczynski & Kesebir, 2011; Solomon et al., 1991) to investigate if such religious facets correlate with and predict PTSD symptoms, world assumptions and posttraumatic appraisals within a community sample of Muslim refugees/ asylum seekers. The emphasis of this study

is on the role of Islam in the cognitive processes of trauma appraisals and coping. Trauma symptoms are used here as a gauge of wellbeing, given trauma experiences, and are not the focus of the study.

# 2. Literature review

The literature review begins by providing an overview of PTSD. Then, key issues within the refugee experience are outlined. Next, religion, its influence on the self and trauma appraisals is examined, including the impact of Islam on believer's perception of self and mental health. This is followed by a review of literature focused on the impact of Islam on the world assumptions and trauma appraisals of Muslim refugees/asylum seekers.

## 2.1. Posttraumatic Stress Disorder (PTSD)

### 2.1.1. Definition, diagnosis and prognosis

PTSD is categorised as a trauma and stressor-related disorder within the DSM-5 (APA, 2013). It is a psychological disorder which can develop when an individual is directly or indirectly exposed to stressors. Of significance to the current research, is criterion D of DSM-5, "negative thoughts and assumptions about oneself and the world", which was not present in previous DSM versions. Given the centrality of trauma appraisals and world assumptions to this study, these guidelines acknowledge the significance of negative trauma appraisals and assumptions, and highlight the substantial evidence base for their function in the development and maintenance of PTSD (section 2.1.3).

Trauma survivors typically experience certain PTSD symptoms immediately after the trauma. Symptoms tend to decline in the months following the trauma (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992), with most trauma survivors displaying heightened resilience, acceptance and post-traumatic growth (Foa & Riggs, 1995; Solomon & Dekel, 2007). There are, however, a significant proportion (25-30%) that go on to develop PTSD (Green, 1994), with 74% experiencing symptoms for more than six months (Bresalu, 2001).

Certain factors can adversely influence the course and severity of PTSD. These include: female gender, ethnic minority status, previous trauma exposure, increased trauma severity, additional stressors following the trauma and low levels of perceived social support (for meta-

analyses, see Brewin et al., 2000; Ozer et al., 2003). Certain cognitive factors, like negative self-appraisals, self-blaming appraisals and rumination, are shown to be the strongest predictors of chronic PTSD (Kleim, Ehlers & Glucksman, 2007). The refugee experience involves exposure to several risk factors for PTSD, which puts this population at an increased danger of trauma-related psychopathology (section 2.2).

### 2.1.2. Psychological Processes

Several psychological processes are involved in PTSD, including memory, attention, social support, cognitive-affective reactions, beliefs, cognitive coping strategies and posttraumatic growth (Brewin & Holmes, 2003). This section focuses on cognitive-affective reactions, beliefs and cognitive coping mechanisms, given their importance to this research.

#### *2.1.2.1. Cognitions and PTSD*

The Cognitive Model of PTSD proposes that cognitions serve a seminal role in the onset and maintenance of the disorder (Ehlers & Clark, 2000). This is supported by studies, which have found that individuals with PTSD report significantly more negative thoughts about the self, world and future compared to non-traumatised survivors (Dunmore, Clark and Ehlers, 1999). Research has also demonstrated that traumas can shatter trust, developing feelings of betrayal (Kelley, Weathers, Mason, & Pruneau, 2012; Martin, Cromer, DePrince, & Freyd, 2013) or creating crises of faith in the goodness of people (Andrews, Brewin, Rose, & Kirk, 2000). Such research highlights the role of cognitive appraisals, the subjective meaning-making process, understanding and evaluation of the trauma experience and its consequences. It provides an assessment of the way in which individuals manoeuvre new and unwanted experiences, thoughts, feelings and behaviours. Appraisals can aid the comprehension of posttraumatic adjustment, recovery and be barriers to this process (Kleim, Ehlers & Glucksman, 2007). Accordingly, cognitive appraisals are integral to theoretical accounts of PTSD (Ehlers & Clark, 2000; Jobson, 2009). This supports the Cognitive Theory of

Psychopathology, where the individual's appraisal of situations rather than the situation itself is said to dictate emotional responses (Beck, 1967; Beck, Emery, & Greenberg, 1985).

Foa, Ehlers, Clark, Tolin and Orsillo (1999) propose three types of negative appraisals contributing towards PTSD: negative cognitions about self (e.g. "I am unworthy"), the world ("the world is a dangerous place") and self-blame (e.g. "what I did led to this event"). Furthermore, negative appraisals of one's trauma responses (e.g. viewing symptoms as a manifestation that one is going crazy), is shown to maintain symptoms and hinder recovery (Dunmore, Clark, & Ehlers, 2001; Halligan, Michael, Clark, & Ehlers, 2003).

Explaining this, Ehlers and Clark (2000) state that the disproportionately negative appraisal of traumas, its consequences or both, maintain PTSD by developing a persistent sense of threat, encouraging unhealthy coping strategies that impede cognitive change. This is supported by cross-sectional (Agar, Kennedy, & King, 2006; Laposa, & Alden, 2003) and longitudinal research (Ehring, Ehlers, & Glucksman, 2008; O'Donnell, Elliott, Wolfgang, & Creamer, 2007), which has revealed significant relationships between negative appraisals and PTSD symptom severity. Several studies demonstrate that negative appraisals of the trauma experience and questioning why the survivor is facing symptoms is found more commonly in those who develop PTSD following an assault, motor accident and especially in those with enduring symptoms (Dunmore et al., 1999; Ehlers et al., 2000; Steil & Ehlers, 2000). Additionally, prospective research shows that negative appraisals of symptoms predicted decreased recovery rates from PTSD. Research has also specifically implicated the role of negative self-appraisals in aetiology of PTSD (Gómez de la Cuesta, 2017). The importance of appraisals is additionally highlighted by results demonstrating that subjective threat-perceptions, in comparison to more objective distress measures (e.g. threat to life), are more powerful predicators of distress and of ensuing treatment outcomes (Alvarez-Conrad, Zoellner, & Foa, 2001; Bernat, Ronfeldt, Calhoun, & Arias, 1998). Consequently, trauma-

related appraisals form an integral part of psychological interventions of PTSD (Resick, 2001).

Alongside cognitive appraisals are cognitive-affective responses, which are critical in PTSD aetiology and maintenance. Cognitive-affective reactions are characterised as being a combination of beliefs and emotions (Brewin & Holmes, 2003). Within PTSD, cognitive-affective reactions include appraisals of isolation (feeling separated from others), perceptions of lasting change (feeling that one's personality or life is permanently altered) and a loss of control/autonomy (feeling that one is unable to have an impact on their fate; Ehlers, Maercker, & Boos, 2000). Additional cognitive-affective reactions involve severe feelings of fear and helplessness, which are shown to predict PTSD amongst those who have experienced violent crime (Brewin, Andrews, & Rose, 2000).

It has been noted, however, that there are a proportion of trauma survivors who report clinically significant PTSD symptoms but who do not report such adverse reactions (Brewin & Holmes, 2003). Brewin and Holmes (2003) acknowledge that while certain emotions are directly related to the trauma experienced, others can emerge following the trauma, when the individual evaluates their experience (cognitive appraisals), examining its cause, their own role and present and future consequences. Therefore, cognitive-affective reactions within PTSD go beyond the trauma itself and involve the continuous cognitive appraisals of the self, world and future.

*2.1.2.2. Beliefs and PTSD*

The importance of beliefs is demonstrated by research among various populations like veterans, political prisoners and assault victims (Dunmore, Clark, & Ehlers, 2001; Kilpatrick & Resnick, 1993). Here, despite danger to life arising as a significant predictor, subjective opinions of danger were found to be more important predictors of distress and treatment outcomes than more objective markers (Alvarez-Conrad, Zoellner, & Foa, 2001; Bernat,

Ronfeldt, Calhoun, & Arias, 1998). PTSD beliefs seem to go beyond the perception of threat. A fundamental notion is that trauma experiences shatter individuals' principal beliefs and assumptions (Bolton & Hill, 1996; Horowitz, 1976, 1986; Janoff-Bulman, 1992).

Accordingly, a rise in negative beliefs about self, world and other has been reported in trauma survivors with PTSD than without PTSD (Dunmore, Clark, & Ehlers, 1999; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999). Several studies highlight the prospect for traumas to devastate perceptions of trust and result in the beliefs of betrayal or abandonment (Freyd, 1997; Shay, 1995). PTSD sufferers also report increased anger towards the other, mistrust and doubt in the goodness of people (Andrews et al., 2000). Studies on torture survivors suggest that prior expectations of torture experiences influence consequent responses (Basoglu et al., 1997). This highlights the importance of pre-trauma beliefs for post-trauma reactions.

Other studies have supported the significance of beliefs about the self. PTSD is linked with the belief that traumas create a negative and enduring change in the self and one's ability to accomplish goals (Dunmore et al., 1999; Ehlers et al., 2000). In shipping accidents, passengers who engaged in self-blame displayed greater PTSD symptoms (Joseph, Brewin, Yule, & Williams, 1991; Joseph, Brewin, Yule, & Williams, 1993). Negative beliefs can, therefore, arise during or in the aftermath of trauma, where the appraisal process ensues.

The Threat to Conceptual Self (TCS) model emphasises cultural differences in self-construal, the way in which a person perceives and builds the self, within PTSD (Jobson, 2009). It claims that distinct cultural self-conceptions value different characteristics, with appraisals resembling the prevailing cultural self-construct. A recent review highlights the role of culture in influencing cognitive appraisals (Bernardi, Engelbrecht & Jobson, 2018). Cultural variations in self-understanding were found to impact appraisals fundamental to PTSD. Specifically, how individuals evaluate experiences with regards to agency, mental defeat and negative self-appraisals. Supporting research investigating cultural differences in

self on negative cognitive appraisals in those with and without PTSD has demonstrated that within individualist cultures, greater mental defeat, alienation, permanent change and less control strategies differentiated between those with and without PTSD (Jobson & O'Kearney, 2009). Within collectivist cultures only alienation appraisals differentiated between those with and without PTSD. These findings demonstrate cultural differences in self influence the interaction between appraisals and posttraumatic adjustment. Of consequence for this research is the link between the pre-trauma cultural beliefs, cognitive appraisals and its resulting impact on trauma responses.

Beliefs that transpired pre-traumatically can become part of the re-experienced trauma memory and be stimulated by trauma-related cues (Grey, Young, & Holmes, 2002). This is important as it brings into question the role and implication of socio-cultural beliefs, like religion, for an individual's post trauma reactions.

*2.1.2.3. Cognitive coping mechanisms*

Cognitive coping mechanisms have been implicated in the development and maintenance of PTSD. There is substantial evidence indicating that efforts to repress or avoid intrusive thoughts and memories are not only unsuccessful but result in a more powerful reoccurrence and lengthier recovery from PTSD (Dunmore et al., 1999; Steil & Ehlers, 2000; Wenzlaff & Wegner, 2000). A study of PTSD rates among 4000 cancer patients in the Gaza strip found that using avoidance strategies was positively correlated with symptoms like hyperarousal and reexperiencing, whereas reinterpretation, problem solving and affiliation strategies were negatively correlated with PTSD symptoms (Al Jadili & Thabet, 2017). Additional coping strategies related to an increased PTSD risk include rumination and worry (Ehlers et al., 1998; Murray et al., 2002; Spinhoven, Pennix, Krempeniou, Hemert & Elzinga, 2015) and greater use of safety behaviours (Dunmore et al., 2001).

Certain coping strategies are associated with posttraumatic growth. For instance, a longitudinal internet-based study following the 9/11 attack found that positive reframing was associated with greater posttraumatic growth at follow-up (Butker et al., 2005). This illustrates the importance of both adaptive and maladaptive cognitive coping in the development and maintenance of PTSD. Significant to this research is the impact of socio-cultural cognitive coping mechanisms, like religion, for individuals' posttraumatic reactions.

Cognitive appraisals, beliefs, coping strategies and their consequent affective reactions are psychological processes associated with the onset and maintenance of PTSD. Negative appraisals, during and in the aftermath of the trauma, are shown to be important on an individual's perception of self, world, future and consequent coping strategies. Beliefs are shown to extend beyond the trauma itself and can involve more universal elements of a person, their social world and future.

### 2.1.3. The Cognitive Model of PTSD

The Cognitive Model (Ehlers & Clark, 2000) is outlined given its focus on cognition appraisals and affective-reactions (i.e. coping mechanisms), which forms the basis of this study. Furthermore, it has had considerable influence both theoretically and clinically. In this model, disturbance in autobiographical memory, unhealthy appraisals and coping strategies create a sense of current threat that is crucial to the development and maintenance of PTSD (Figure 1).

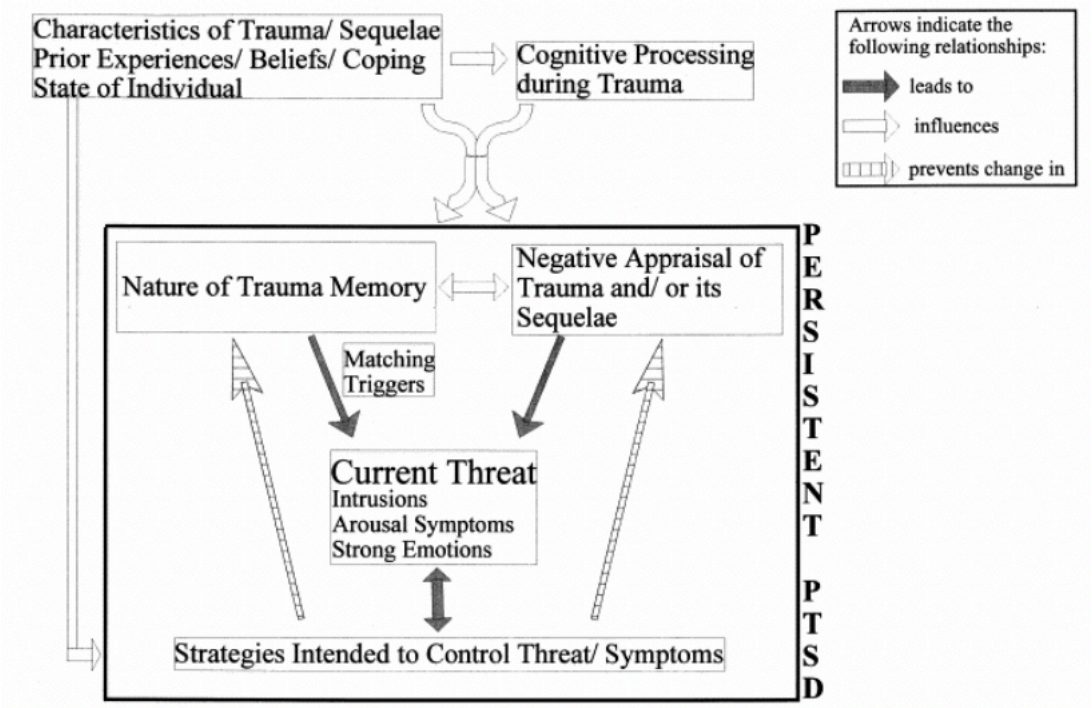


Figure 1. *The Cognitive Model of PTSD (Ehlers & Clark, 2000)*

The disturbance created by trauma to an individual's autobiographical memory, causes memories to be poorly integrated into existing memories and decontextualized, due to poor conceptual processing during the event. Consequently, trauma memories are recalled in a fragmented and distorted way. Ehlers and Clark (2000) use the Self-Memory System (SMS) account to explain the interferences and misrepresentations apparent in the autobiographical memories of survivors. The SMS holds that trauma exposure presents a risk and challenges active goals, beliefs and assumptions (e.g. the world is a safe place, people are good; Conway & Pleydell-Pearce, 2000). The working self is unable to accommodate the trauma experience as there are no present goals that can incorporate this memory into the existing autobiographical knowledge base. Hence, the trauma memory stays an unincorporated, uncontextualized situation-specific depiction that becomes linked to the working self and its goals. This creates PTSD symptoms, like reexperiencing and intrusions. Trauma memory can, however, be activated in the future through the initiation of goals linked to the working self.

Given the inadequate link with present autobiographical memories, trauma memories in individuals with PTSD are typically recovered through a direct route. Consequently, exposure to trauma-related stimuli produces involuntary triggers of the non-contextualised trauma memory (Conway, 2005). Likewise, re-experiencing symptoms are thought to arise due to the absence of a temporal and spatial context for trauma memories. Therefore, the model suggests that trauma-related reminders stimulate the re-living of the historic situation, generating a sense of imminent danger.

With regards to cognitive appraisals, the model holds that an individual's previous beliefs and experiences considerably impact their post-trauma appraisals. Consequently, psychological defeat, prior trauma exposure, helplessness or vulnerability, raises susceptibility for the posttraumatic self being evaluated as vulnerable, futile and frail. Such evaluations are said to generate a sense of danger to the self, which can be external (e.g. "others are untrustworthy") or internal (e.g. "I am to blame"). Of importance to this study, the model proposes that coping strategies used by those with PTSD, in preserving their safety and diminishing distress, are linked to the person's evaluation of the trauma and their overall beliefs about coping.

Negative appraisals are said to maintain PTSD as they generate negative affect that stimulate the use of maladaptive coping strategies (e.g. avoidance), consequently worsening PTSD symptoms. The model states that while avoidance and safety-seeking behaviours decrease symptoms temporarily, they hinder cognitive change, sustaining the lasting consequences of PTSD. Research has shown the detrimental impact of thought suppression. A study on individuals with PTSD demonstrated that suppression of trauma-related memories and images resulted in an increase of intrusive symptoms (Shipherd & Beck, 2005). Similarly, longitudinal studies on road traffic accident survivors demonstrate that avoidance and mental suppression were predictors for chronic PTSD (Ehlers, Richard, Mayou, & Bryant, 1998).

Furthermore, rumination (Ehlers et al., 1998; Murray, Ehlers, & Mayou, 2002) and extreme use of safety behaviours (Dunmore et al., 2001) escalated the risk of future PTSD. Ehlers and Clark's (2000) model has received substantial empirical support (section 2.1.2.1).

Studies on PTSD interventions have demonstrated the beneficial nature of psychological therapy, which challenge maladaptive appraisals of the self, world and other (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005; Hagenaars, van Minnen, & de Rooij, 2010; Vogt, Shepherd, & Resick, 2012). Kleim et al. (2013) examined the temporal association between alterations in negative appraisals and symptom decline. Findings demonstrate that, after treatment, there was a decrease in PTSD symptoms and alterations in dysfunctional trauma appraisals. Intriguingly, findings also demonstrated that alternations in appraisals markedly predicted consequent decline in symptom severity. Therefore, trauma interventions, like trauma-focused cognitive behavioural therapies have a fundamental aim to target and change negative appraisals within therapy (Resick, 2001).

The Cognitive Model of PTSD highlights the function of trauma-related appraisals and consequent coping strategies in the maintenance and treatment of PTSD. Of significance to this study, the model proposes that an individual's beliefs and experiences have an important impact on the composition and prospect of appraisals including their post-trauma coping strategies. Compatible with this, Pargament's (1997) Religious Coping Theory, proposes that religion offers its believers a sense of meaning, and coping strategies during times of distress. Thus, if Islam, like Christianity, also provides a framework for life, then in line with the Cognitive Model of PTSD and Religious Coping Theory, it may also influence the maintenance and recovery of PTSD for Muslim trauma survivors.

A central component in the clinical application of Ehlers and Clark's (2000) model is acknowledging and understanding an individual's meaning-making process associated with the trauma, which makes this model theoretically considerate towards theological and cross-

cultural deliberations. The Cognitive Model (Ehlers & Clark, 2000) suggests two principle elements for PTSD treatment. Firstly, through repeated exposure, individuals with PTSD are supported to recall trauma-related memories to incorporate this material into existing autobiographical memories. Secondly, individuals are encouraged to practice a process of conscious meaning-making of the trauma to reduce differences between the trauma memories and existing beliefs and expectations. Cognitive coping is also emphasised, maintaining that certain coping methods can promote adaptive thinking and behaviour, whereas others can be more detrimental. Despite the vast research on PTSD within Western contexts, research and understandings of PTSD outside this population remains limited but crucial (Foa et al., 2009).

## 2.2. Refugee/asylum seeker experience: refugees/asylum seekers & mental health

The plight of refugees/asylum seekers poses several health and safety risks. Research on refugee mental health over the past two decades demonstrates, firstly, the high level of trauma exposure within the pre-migration phase and challenges encountered during migration and post-migration (Priebe, Giacco, El-Nagib, 2016). Secondly, studies demonstrate that such exposure forms risk factors for potentially enduring psychiatric disorders like PTSD, depression and anxiety (Fazel, Reed, Panter-Brick & Stein, 2012). Thirdly, findings show that many who experience such adversities do not go on to develop psychiatric disorders and demonstrate great resilience.

Recent research has highlighted high rates of PTSD, anxiety and depression among current refugee samples (De Jong et al., 2016; Kazour et al., 2017). Epidemiological studies have demonstrated that age-standardised point prevalence of PTSD and depression within conflict regions is approximately 12.9% and 7.6% respectively (Charlson et al., 2016). This is in comparison to approximate rates of PTSD at 4.4% and major depression at 4.4% within the global population (WHO, 2017; Stein et al., 2014). Other mental health conditions have also been noted to a lesser degree, for example, bereavement-related disorders, psycho-somatic

disorders and existential crises. A systematic review of research on mental health in Syria and surrounding areas highlighted significantly high rates of fear, fatigue and grief as well as physical violence and torture (Quosh, Eloul, & Ajlani, 2013). Given this, it becomes important to examine risk, resilience and the socio-cultural factors impacting current refugees/asylum seekers in comprehending the impact of the refugee experience on mental health.

2.2.1. Pre- & post-migratory factors

The refugee/asylum seeker experience is characterised by exposure to multiple traumas in different socio-political contexts (Bracken, Giller, Summerfield, 1995; Hollifield et al., 2002). Research demonstrates the adverse effect of pre- and post-migratory experiences on refugee mental health (Thomas & Thomas, 2004). This is well supported across different populations (Laban, Komproe, Gernaat, & De Jong, 2008; Steel, Silove, Bird, McGorry, & Mohan, 1999) and by review studies. One meta-analysis of refugee mental health using a world-wide sample examined moderators of mental health outcomes within research published from 1995-2002 (Porter & Haslam, 2005). Post-migration context was found to moderate mental health outcomes. Poorer outcomes were associated with refugees residing in institutional accommodation, having limited economic opportunities, being internally displaced, deported to their countries or those whose countries continued to undergo conflict. Also with poorer outcomes were refugees who were older, female, educated, had greater pre-migratory socio-economic status and those from rural areas.

Similarly, a systematic review of research on the long-term mental health of war-impacted adult refugees demonstrated a higher risk even after five or more years of displacement (Bogic, Njoku, & Priebe, 2015). This was influenced by pre-migration trauma and post-migration factors. Specifically, post-migratory socio-economic factors (i.e. unemployment, low income, poor host language proficiency, and lack of social support) were associated with

depression. Additionally, being female was associated with unspecified anxiety, although not with PTSD. More recent reviews supports previous findings on post-migration factors affecting the refugee mental health (LeMaster et al., 2017; Li, Liddell & Nickerson, 2016). These highlighted the role of socio-economic, social, interpersonal and acculturation difficulties, including English language skills, in addition to immigration-related stressors. The vulnerability of recent refugees, asylum seekers and undocumented migrants, especially women is further highlighted in research on sexual and gender-based violence (SGBV) in Belgium and the Netherlands (Keygnaert, Vettenburg, & Temmerman, 2012). Most individuals reported abusive experiences, since their arrival into the European Union. Three hundred and thirty two experiences of SGBV were reported involving largely (ex)partners or asylum professionals.

These studies provide strong support for an understanding of pre- and post-migration contextual factors in considerations of refugee/asylum seekers mental-health. This emphasises mental health being impacted not only by the context from which they fled but also the context in which refugees/asylum seekers currently find themselves (Bracken, Giller, Summerfield, 1995; Hjern, Angel, Jeppson, 1998).

### 2.2.2 Discrimination

Another factor relevant to refugee/asylum seekers acculturation and mental health is discrimination. Historically, there has been an uncertainty associated with the receipt of refugees, with public perspectives varying from heroes to intruders (Pandya, 2016). Current refugees/asylum seekers arrive at a time of austerity, with an increase of terrorism with extremist Islamic connections, like the recent attacks on European countries, inspired by the so-called Islamic state (Zunes, 2017). This has fuelled a climate of Xenophobia and Islamophobia (Bayrakli & Hafez, 2016). It has also influenced the rise in anti-immigration government policies, like creating a ‘hostile environment’ for illegal migration within the UK

(Bolt, 2016) and increased the rates of hate crime towards immigrants in Europe (Bayrakli & Hafez, 2016).

Past research on discrimination among refugees has demonstrated associations with depression (Noh, Beiser, Kaspar, Hou, & Rummens, 1999) and impediments to acculturalisation and negative self-perceptions, motivation and accomplishments (Portes & Rumbaut, 2001; Suarez-Orozco & Suarez-Orozco, 2001). There remains a scarcity of research on the impact of discrimination among refugees/asylum seekers from the current crisis. Alemi and Stempel (2018) found among Afghan refugees in California that perceived discrimination was significantly correlated with elevated distress levels. This association was greater among individuals with a strong intra-ethnic identity and high pre-resettlement trauma. Contrastingly, strong in-group identification was shown to play a protective role with psychological benefits. Similarly, a study among Syrian refugees in Turkey found that greater perceived ethnic discrimination was linked to lower physical and mental health but not for those gaining a sense of worth from their Syrian identity (Çelebi, Verkuyten & Bagci, 2017). Greater Syrian identification was related to lower depression and anxiety, which was stronger for those gaining a sense of belonging and continuity from their Syrian identity. Such findings suggests that motivational elements of identity, like group identification, are crucial for considerations of discrimination and the psycho-physiological wellbeing of refugees. This is relevant as it raises questions about the impact of religious identification among Muslim refugees/asylum seekers within the current context.

There is also research demonstrating that not everyone exposed to negative life events, like discrimination, are adversely impacted and that individuals may grow in the face of such experiences (Ryff, Keyes & Hughes, 2003). Werkuyten and Nekuee (1999) found among Iranian refugees in the Netherlands that a sense of mastery, not perceived discrimination or minority status identification, predicted positive emotions and life satisfaction. It is suggested

that refugees directed their efforts to their current rather than past traumatic context. Fozdar and Torezani (2008) also found that whilst discrimination was experienced by most refugee participants in Australia (e.g. racism, job market discrimination, Islamophobia), they reported a general positive quality of life and life satisfaction. Interestingly, these experiences did not seem to impact perceptions of fairness of Australia as a country. Additionally, Pettigrew (2002) found that refugee participants displayed the relative gratification effect, drawing comparisons with worse experiences, in expressions of life satisfaction. Such findings illustrate a complex relationship between wellbeing and discrimination, highlighting the growth that may result from difficulties.

### 2.2.3. Posttraumatic growth

Harmonious with the above findings, individuals experiencing trauma can go on to develop an optimistic outlook and undergo positive psychological changes. This perspective aligns with the positivistic school of thought (Seligman & Csikszentmihalyi, 2000) and past salutogenic models (Antonovsky, 1979). This is known as Posttraumatic growth (PTG; Tedeschi & Calhoun, 1996), where the trauma has a transformational impact that precedes their pre-trauma state of psychological functioning. This results in a greater propensity for personal vigour, gratitude for life, life outcomes and spirituality (Dekel, Ein-Dor & Solomon, 2012). There is evidence consistently reporting PTG in survivors of diverse physical and psychological trauma (Calhoun & Tedeschi, 1989; Schwartzberg, 1993). Several studies have also reported positive associations between PTG and posttraumatic stress symptoms in various refugee populations (Hussain, & Bhushan, 2011; Kılıç, Magruder & Koryürek, 2016; Kroo, & Nagy, 2011).

Teodorescu et al. (2012) examined PGT, PTSD, depressive symptoms, post-migration stressors, and their correlation with quality of life among 45 outpatient psychiatric refugee patients in Norway. Findings demonstrate that all participants reported PTG to an extent, with

31% reporting higher PTG. 80% of the sample had PTSD symptoms greater than the cut-off and 93% reported clinical levels of depression. A hierarchical regression model of depressive symptoms, posttraumatic stress symptoms, posttraumatic growth, and unemployment found that PTG contributed most significantly to the model. Such findings suggests that both growth experiences and psychopathological symptoms need to be considered in understandings and treatments of mental health among refugees/asylum seekers.

2.2.4. Culture

Culture is shown to influence models of mental health and explanatory health beliefs, with Western frameworks adopting a more individualistic focus, while other cultures have a community focus (Tribe, 2005). Consequently, it is questioned whether Western models are adequately able to capture and understand resilience, socio-political, cultural and spiritual factors related to mental health. Indeed, while certain phenomena may be identified in various contexts, it may not necessarily carry the same meaning (Kleinman,1987). As Blackwell (1989) states:

> It is all too easy to repeat the colonising process by imposing a therapeutic ideology rooted in the culture of the host community, giving meaning to the survivors' experience in the language and symbols of that host community and its professionals, and failing to recognise the rich sources of meaning and symbolism available to the survivor from his or her own culture. (p. 2)

Literature on PTSD and cultural factors demonstrates the ethnic differences in perceptions of PTSD (Parson, 2013). Such authors highlight the discrepancy between those meeting diagnostic criteria but not necessarily demonstrating the accompanying expectant reactions. A review of the psychosocial wellbeing among Sudanese refugees found that while quantitative studies reported high rates of psychopathy (Tempany, 2009), especially PTSD and depression (Kim et al., 2007), mixed methods research demonstrated that the presence of PTSD

symptoms did not necessarily impact participant functioning (Jeppsson & Hjern, 2005; Summerfield 2002). Qualitative studies report that individuals were more apprehensive about present stressors like family issues than past traumas (Baron, 2002). Such discrepancies has created a debate around the cross-cultural validity of PTSD construct, with authors varying in their conceptualisation and interpretation of PTSD, from attributing distress to historical traumas resulting in psychopathology to customary reactions given the trauma previously and concurrently experienced. Other authors (Peltzer, 1998) have argued that PTSD may be partly but not wholly appropriate for the likes of Sudanese refugees, contending that the assumption that traumas are based within the individual, maybe unsuited to the Sudanese population whose self-perception is in relation to others within the community. Therefore, the co-existence of distress and resilience illustrates the need for clinicians to consider both resilience and psychopathology-focused approaches for refugee/asylum seekers populations.

There may also be cultural variations in how psychological distress is presented and in expectations of treatments and recovery (Newland & Patel, 2005). A qualitative study on the influence of the collectivist culture on trauma appraisals found that firstly, trauma consequences were perceived in relation to the one's group, with the self as a secondary characteristic (Engelbrecht, & Jobson, 2016). Secondly, trauma appraisals were evaluated based on cultural values, standards and expectations. When these were disrupted individuals appeared to engage in self-blame. Thirdly, certain participants ascribed experiences as being predestined by God, fate or other external causes. This was linked to religious coping methods like prayer or cleansing rituals. Finally, traumas were appraised as largely physiological in nature.

Additionally, stigmatisation seemed to play an important role in the somatisation displayed by refugees (Laban, Komproe, Gernaat, De Jong, 2008). Refugees were found to prefer medical than psychiatric treatment due to fears over perceptions of being 'crazy' by their

cultural communities. This perhaps provides an explanation for the low mental health service usage among refugees (Miller, 1999), with community-based services and alternative interventions (e.g. art, drama and sport therapy) found to be more culturally acceptable and consequential for refugee populations (Miller & Rasco, 2004; Tribe, 2002). Such findings demonstrate the importance of acknowledging, exploring and comprehending different health beliefs and narratives, especially given the low mental health service usage among this population.

The above evidence does not stand to discount the diagnostic process but calls for the integration of cultural, socio-political and spiritual factors within the assessment, diagnostic, and treatment process of trauma. Whilst there is evidence of high rates of mental health disorders among refugees, there are also discrepancies in findings demonstrated by mixed-methods research. Indeed, current guidelines on working with refugees/asylum seekers call for a shift from a pathological perspective to capturing resilience and cultural factors, including examining the totality of the refugee/asylum seeker experience, pre-migration, migration and post-migration (Patel et al., 2017; Tribe, 2005). According to Religious Coping Theory (Pargament, 1997), religion, in providing meaning for its adherents, influences coping strategies, which raises questions about the role of religion in trauma experiences and responses.

## 2.3. Religion & Trauma

Religion can provide a means by which individuals seek to comprehend and cope with life (Pargament, 1997):

> Religion generally helps people appreciate what they themselves cannot control. It highlights the limitations of material goods, personal desires, and individual lives…[and] offers a way to come to grips with these limitations through frameworks of belief that go beyond oneself. (p.8)

Trauma and religion intermingle as an individual experiences, and recovers, from a catastrophic event. Thus, it is imperative to investigate the relationship between these factors using a mutualistic approach, examining how trauma impacts religion and how religion impacts trauma (Smith, 2004).

### 2.3.1. The Impact of trauma on religion

Traumas highlight complex and ambiguous existential questions (Pargament, 2007) and challenge fundamental schemas upheld by individuals (Hamilton, Greenberg, Pyszczynski & Cather, 1993). This forms the foundation of several psychological models of trauma including Ehlers and Clarke's (2000) PTSD model. Worldview-based trauma models, like the Shattered Assumptions Theory, Terror Management Theory (TMT; Solomon, Greenberg & Pyszczynski, 1991) and Anxiety Buffer Disruption Theory (ABDT; Abdollahi, Pyszczynski, Maxfield & Luszczynska, 2011), provide an understanding of how traumas can affect an individual beliefs.

#### *2.3.1.1. Shattered Assumptions Theory*

According to Shattered Assumptions Theory, traumas threaten an individual's perception of themselves and the world (Janoff-Bulman, 1992). Specifically, traumas are said to challenge key underlying assumptions of life: the world is a benevolent (i.e. "there is sense of justice") and meaningful (i.e. "good things happen to good people") place and that the self is worthy (i.e. "I am a good person"). These implicit assumptions provide people with a sense of security, meaning and self-esteem, allowing individuals to persevere with life, despite its uncertainty.

Brewin and Holmes (2003) broadened these assumptions with the inclusion of the world being predictable and people being invulnerable. When individuals experience trauma, the trauma memory does not fit with existing worldviews, making it difficult to integrate into existing memories. Therefore, individuals are said to lose the perception of the world being

benevolent and predictable, themselves as being worthy and invulnerable. This is thought to create anxiety and results in the psycho-physiological symptomology of PTSD. Significantly, such responses are elicited because of the threat to the fundamental assumptions and the heightened awareness of individual mortality.

This theory seems to offer a compelling basis for PTSD. Evidence supporting it, however, has been unclear. Studies assessing the theory have largely utilised the World Assumptions Scale (WAS; Janoff-Bulman, 1989), which is demonstrated to have psychometric issues (Elklit, Shevlin, Solomon, & Dekel, 2007; Kaler et al., 2008). Several inadequacies have been found, including issues around validity. Given this, a new assumptive world measure was developed, the World Assumptions Questionnaire (WAQ; Kaler, 2009). Findings from repeat administrations of WAQ demonstrate strong psychometric properties, which overcomes problems associated with the WAS. This forms the basis for utilising the WAQ within this study. The TMT (Solomon et al., 1991) and ABDT (Abdollahi et al., 2011) extend Janoff-Bulman's (1992) theory further, these are outlined below.

*2.3.1.2. Terror Management Theory*

Like the above theory, TMT holds that worldviews provide individuals with feelings of meaning, purpose and invulnerability (Greenberg et al., 1986). It stipulates that humans have an unavoidable awareness of mortality, which induces a sense of psychological terror, especially when forced to confront this (for a review see Solomon, Greenberg, Pyszczynski, & Koole, 2004).

TMT posits that individuals develop psychological defences to manage such terrors and traumas: cultural worldviews, self-esteem and close relationships. These provide a persistent belief in a worldview and self that denies the uncertain and ephemeral essence of one's existence. Accordingly, cultural worldviews, like religion, are said to provide life with a sense of order, meaning, purpose and a way of existence beyond death, literally, through an eternal

soul, or symbolically, through a death surpassing identity. Self-esteem and close relationships, may also help manage this state of terror by providing internal psychological security, which forms a barrier against anxiety. Striving to meet the expectations of cultural worldviews and having close relationships is said to provide a sense of meaning and worth (self-esteem striving; Pyszczynski, Greenberg, Solomon, Arndt, & Schimel, 2004). Accordingly, terror can be managed through beliefs in a meaningful cultural, one's own worthiness towards a meaningful world and social support.

TMT has received substantial support in various fields and countries. Research on TMT has largely demonstrated that 1) increasing validation of one's worldview and self-esteem, removes the effect of mortality salience on self-esteem striving and the worldview defence (Solomon et al., 2004); 2) threats to one's worldview and self-esteem increase death-related cognition accessibility and increase self-esteem and faith in one's worldview; 3) belief in an afterlife removes the effect of mortality salience on the worldview defence and self-esteem striving (see Pyszczynski, et al., 2004 for a review).

Research on TMT has also outlined the time progression of a terror incident eliciting mortality salience. Proximal defences are thought to be perceived directly after death reminders and involve a denial of death. Distal defences appear when proximal defences diminish, explicit reminders of mortality shift to the edges of consciousness and death thoughts become extremely accessible (e.g. following a delay and a distraction task; Arndt et al., 2004). Such studies may have implications for trauma reactions among present and mid- to long-term resettled refugees.

Critics of TMT argue that risks other than death can generate effects comparable to mortality salience like uncertainty (van den Bos & Miedema, 2000) or social isolation (Navarette, Kurzban, Fessler & Kirpatrick, 2004). This suggests that there are influences

beyond death that can increase one's faith in a worldview (Greenberg, et al., 1990; Rosenblatt et al., 1989).

*2.3.1.3. Anxiety Buffer Disruption Theory*

The ABDT (Pyszczynski & Kesebir, 2011) utilises TMT to explain the varying reactions to trauma and the onset and maintenance of PTSD. Figure 2 provides a visual representation of the ABDT, where the typical anxiety-buffering role of worldviews, close relationships and self-esteem is disrupted by the trauma, leaving individuals vulnerable against the terror of mortality. This results in PTSD symptoms like reexperiencing, avoidance and hyperarousal. The cognitive interchange between intrusive thoughts regarding the trauma and the avoidance of trauma-related reminders indicates efforts to incorporate the trauma event into the worldview to re-establish the anxiety-buffer ability. Such a disruption results in individuals with PTSD being unable to react to mortality reminders in the defensive manner that healthy individuals do. ABDT like the Shattered Assumptions Theory emphasises the existential issue at the core of PTSD symptoms, however, it also highlights the implications of this disruption of worldview functioning.

There is a large body of evidence supporting ABDT using a variety of trauma experiences and cultures. Findings have consistently demonstrated that those with PTSD do not show expectant responses when faced by mortality thoughts (Pyszczynski & Kesebir, 2011). Abdollahi et al.'s (2011) longitudinal study of survivors from the 2005 Iranian earthquake demonstrated that those with severe trauma symptoms show no indication of the worldview defence after mortality reminders of the earthquake, whereas those with low symptoms reacted with the worldview defence. Such findings provide support for the interruption of the anxiety-buffering role of worldviews in the development and the maintenance of the trauma symptomology.

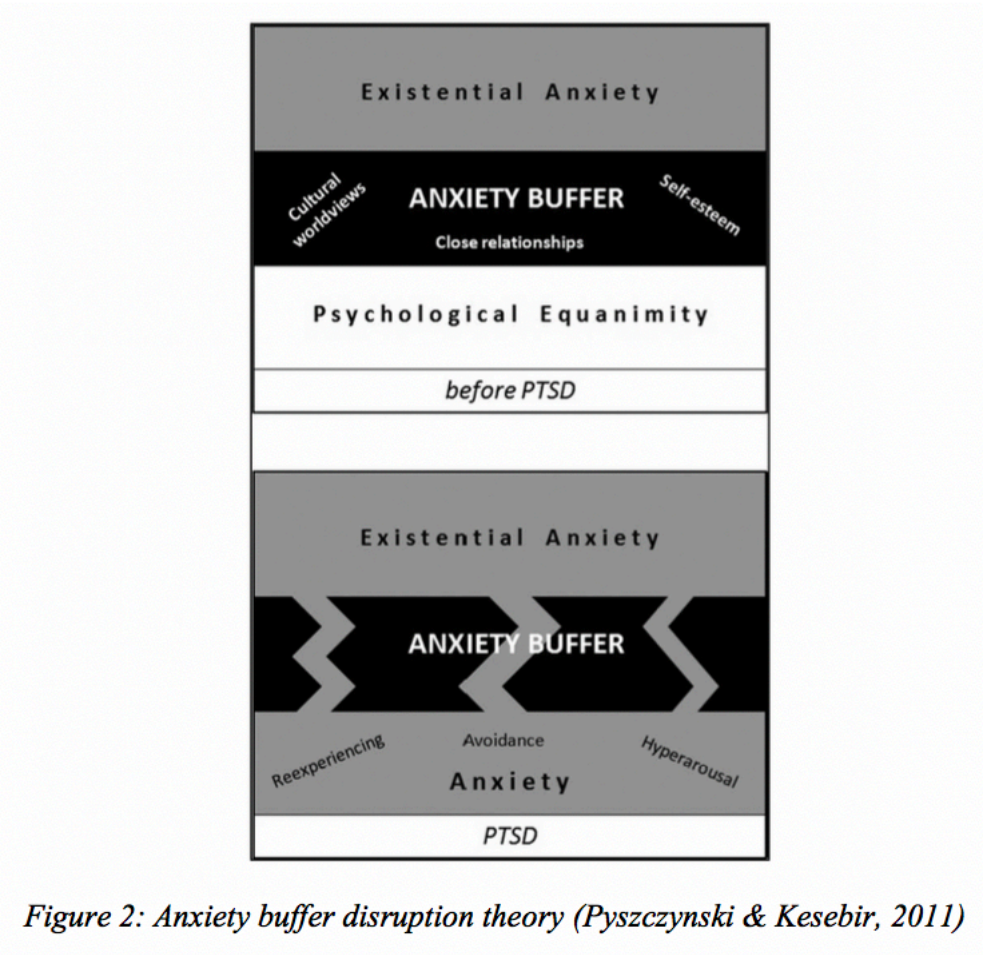


*Figure 2: Anxiety buffer disruption theory (Pyszczynski & Kesebir, 2011)*

Worldview-based models highlight the impact of traumas on an individual's core assumptions. Given that such core assumptions may derive from cultural worldviews like religion, the impact of religion on trauma is of interest to this study.

2.3.2. The impact of religion on trauma

A key role of religion is its meaning-making process, particularly during times of distress. A review by McIntosh (1995) suggests that religion can be perceived as a cognitive schema, which apprises individual's beliefs about self, others and the world. This is in accordance with the Meaning-Making Model (Park, 2005), where meaning-making frameworks, like religion, provide both global and situational meanings. Global meaning involves a) fundamental beliefs about the self, world, other people and, potentially, a higher power, b) beliefs that direct goals, and c) provide a personal sense of motivation in life (Park, 2005; Park & Folkman, 1997).

Situational meaning refers to the way in which global meaning is practiced, influencing the evaluations of events and driving individual motivation towards their global goals (Park, 2005). The role of religion in traumas is important given the implication of cognitive schemas and pre-trauma beliefs within PTSD (Brewin & Holmes, 2003; Ehlers & Clark, 2000).

Religion appears to be a moderating force, impacting the degree of damage and PTG that individuals may experience (Tedeschi & Calhoun, 1996). A systematic review of religion, spirituality and PTG reported three main findings (Shaw, Joseph & Linely, 2007). Firstly, religion/spirituality is typically, but not always, advantageous following a traumatic experience. Secondly, trauma experiences can result in a strengthening of religion/spirituality. Thirdly, positive religion coping, religious openness, willingness to face existential questions, religious involvement and intrinsic religiousness were frequently related to PTG. These findings highlight the role of religious beliefs in posttraumatic adjustment.

*2.3.2.1. Religion as a coping mechanism*

The use of religion to cope during times of difficulty is well established (Pargament, Smith, Koenig & Perez, 1998). Pargament (1997) describes religious coping as multidimensional in facilitating individuals to seek and provide meaning for situations (religious appraisals), problem-solve (through religious methods of managing distress and encouraging hope) and offer comfort, a sense of community and affinity. Pargament (1997) emphasises three elements that allow individuals to adopt religious coping. From a personal perspective, individuals who are already religiously obliged tend to turn to religion during key moments. Situationally, religious coping tends to be utilised during times of distress. Contextually, religious coping is more frequently adopted within a cultural context, for example, in religious societies. Such considerations seems particularly relevant for refugees/asylum seekers given their origins from predominantly Muslim societies and their multiple trauma exposures.

Religion can have both a positive and negative effect on coping (Pargament, Koenig & Perez, 2000). Positive religious coping refers to the way in which religion can function as a support mechanism, for example, creating a deeper spiritual association and bond with the divine and an increased sense of spiritual comfort and trust. Conversely, negative religious coping refers to spiritual struggles, where individuals come to foster feelings of anger, uncertainty (Pargament, et al., 1998) and perceive their trauma as a punishment or abandonment from God (Fallot & Heckman, 2005). Such categorisations offer an understanding of the ways in which spirituality can be an adaptive or maladaptive force for trauma responses.

*2.3.2.2. Empirical research on religious coping*

Several studies have examined positive and negative religious coping patterns and psychological wellbeing. Positive religious coping is shown to yield advantageous outcomes. Specifically, decreased anxiety levels (Cole, 2005), depression (Braxton, Lang, Sales, Wingood, & DiClemente, 2007), hopelessness (Arnette, Masacro, Santana, Davis, & Kaslow, 2007), psychological distress (Pargament, et al., 1998) and greater life satisfaction (Lee, 2007). Negative religious coping is associated with diminished psychological wellbeing including reduced quality of life, physiological issues, poorer interpersonal relations and an increased risk of severe psychological conditions like PTSD, anxiety and depression (Smith, 2004; Cole, 2005; Khan & Watson, 2006). Therefore, religious coping pattern is shown to influence wellbeing.

Zukerman & Korn (2014) examined the relationship between post-traumatic stress, world assumptions and religious coping among Israeli undergraduates. Findings demonstrate that positive religious coping was significantly related to more positive world assumptions, whilst negative religious coping was significantly related to more negative world assumptions. Moreover, negative world assumptions were significantly correlated with

more avoidance symptoms. The authors suggest that religious cognitive schemas have an impact on world assumptions by providing a 'protective shield' function that counteracts the negative impact of being faced with adverse experiences. This study is of interest, as it raises questions about the impact of world assumptions and trauma symptoms for Muslim trauma survivors. Such studies provide insight into and are representative of findings on religious coping from Judeo-Christian traditions (Ano & Vasconcelles, 2005; Cole, 2005; Pargament et al. 2000).

Similar findings have been demonstrated among Muslim samples. A particularly pertinent study examined Islamic appraisals (appraisals of situations using Islamic beliefs), trauma-related appraisals and religious coping among Muslim trauma survivors in the UK (Study 1) and northern Iraq (Study 2) (Berzengi, Berzenji, Kadim, Mustafa & Jobson, 2017). Findings demonstrate that firstly, negative religious coping distinguished between trauma survivors with and without PTSD (Study 1), and was significantly associated with PTSD symptoms (Study 2). Secondly, negative Islamic appraisals were significantly correlated with greater PTSD symptoms, whilst positive Islamic appraisals were significantly correlated with fewer PTSD symptoms (Study 2). Thirdly, negative trauma-related appraisals significantly predicted PTSD symptoms (Study 2). Lastly, trauma-related appraisals were found to mediate the association between negative Islamic appraisals, negative religious coping and PTSD symptoms. Such findings indicate that not only are trauma-related cognitions pertinent to the comprehension of PTSD in Muslim trauma survivors but that trauma-related appraisals and consequent coping strategies may be impacted by Islamic beliefs and values.

These findings on Muslim trauma survivors have been supported. A study of Iranian–Iraqi disabled war veterans demonstrated that when physical function, social support and personal meaning were controlled, religious coping significantly influenced mental health indicators, including general mental health and PTSD beyond other predictors (Aflakseir & Coleman,

2009). Furthermore, participants reported using positive religious coping (e.g. religious practices and benevolent reappraisals) far greater than negative religious coping in dealing with their physical disability and trauma experiences. Likewise, a qualitative study on immigrant Muslim women and their experiences following 9/11 reported that the main source of their resilience was their religion (Abuzahra, 2004). Findings demonstrate that religion played a seminal role in providing an intrinsic and extrinsic source of support. The close and positive relationship with God was a significant source of support. These findings add support to the coping literature among Arab Muslims in the US following 9/11 (Beitin, 2003; Beitin & Allen, 2005). Studies also demonstrate that while religious practices predicted greater discrimination, religion also served as a protective factor (Jasperse et al., 2012), which emphasises the importance of religion for Muslims in the face of adversity.

Despite the close link between trauma and religion, findings remain inconsistent (for review see Chen & Keonig, 2006). Some studies reveal weak associations between positive religious coping and depression (Braxton et al. 2007) and between negative religious coping and depression (Sherman et al., 2005). Other studies have found non-significant correlations between positive religious coping and psychological wellbeing (Braam et al., 2010; Hebert, Zdaniuk, Schulz, & Scheier, 2009) and between negative religious coping and psychological distress, for example, among university students in the Middle East (Gardner, Krägeloh, & Henning, 2014). Methodological discrepancies may explain these inconsistencies, with studies examining populations differing in religious affiliations, ethnicities and presenting issues (Chen & Koenig, 2006).

Overall, the literature demonstrates that positive religious coping is associated with psychological wellbeing, whereas negative religious coping is linked with poor psychological wellbeing (Faigin, Pargament, & Abu-Raiya, 2014). Whilst research is gathering momentum beyond Christian traditions, studies remain limited in traditions like Islam (Abu-Raiya &

Pargament, 2011; Ano & Vasconcelles, 2005). The next section examines Islam and its influence on its followers' perspectives.

## 2.4. Islam

*Islam* in Arabic translates to peace and surrender, and a Muslim is one who voluntarily surrenders to God (Esposito, 1999). Islamic faith is derived from two central sources, the Quran, believed to be the word of God, and Sunnah, empirically documented teachings and practices of Islam's final prophet, Muhammed. Islam is perceived as a framework for life, with the Quran and Sunnah said to be applicable to all elements of life (Armstrong, 1993).

### 2.4.1. Central principles

Islam describes the universe as a dynamic, integrated and meaningful entity, with God as the creator and sustainer of the universe, heavens and earth (Armstrong, 1993). It contains certain essential beliefs that govern faith and form the basis of submission (Sarwar, 2000). Significant to this study are beliefs in a) divine will, where whilst individuals are said to have free will, their lives are pre-destined by God, who is aware of past, present, and future, b) the day of judgement, where every individual is held to account and c) the afterlife, where individuals' behaviours in their lifetime have direct consequences for their eternal lives.

### 2.4.2. The individual and society

Islam encourages a peaceful relationship between the individual and society, with worship of an individual and collective nature. Individual worship is both internal (e.g. through prayers and virtues like gratitude, patience and humbleness) and external (e.g. through one's behaviour). Muslims are also encouraged to emulate prophetic virtues (Armstrong, 2007). Collective worship is encompassed within the concept of *Ummah*, the community of believers, which forms the foundation of Muslim social identity. Islam fosters a sense of community through collective acts of worships (prayers, pilgrimage, fasting), thereby integrating religious beliefs, personal and social identities (El Azayem & Hedayat-Diba,

1994). Therefore, Islam promotes a sense of self that encourages an interconnectedness between the individual and society (Peter, 1993).

Self-concept varies according to culture (Markus & Kitayama, 2010), with Western societies valuing independence and uniqueness, whilst collectivist societies perceive the self in relation to and as part of the wider society (Jobson, 2009; Sato, 2001). The self-construct within Islam is arguably collectivist, thereby indicating that Muslims' motivations, judgements, attitudes, and values are interconnected with that of their community (Ben-Ari & Lavee, 2004; Dwairy et al., 2006; Joseph, 1996; Lam & Zane, 2004). Consequently, such collectivistic underpinnings are important as they impact trauma appraisals and coping strategies in dealing with wellbeing generally and trauma specifically (Engelbrecht & Jobson, 2016; Jobson & O'Kearney, 2009).

2.4.3. Mental illness and healing

There are various beliefs about the origins and treatment of mental illness among Muslims. God's will is shown to influence beliefs about destiny and fate in the lives of Muslims (Husain, 1998; Inayat, 2005). Therefore, mental illnesses can be viewed by Muslims as part of God's plan. Another belief is that adversities are a means of purifying one's sins, through patience, thereby attaining closeness to God. Consequently, patience is encouraged as a method of coping with distress (Khan, Sultana, & Watson, 2009).

Other beliefs around mental illness reflect ethereal dimensions of the Islamic faith, including possession of supernatural spirits (*jinns*), black magic or the evil eye (the influence of envy or jealousy creating physical or emotional damage; Dein, Alexander & Napier, 2008) (Hanley & Brown, 2014; Khalifa, Hardie, Latif, Jamil, & Walker, 2011; Mullick, Khalifa, Nahar, & Walker, 2013). This has been demonstrated in studies examining attitudes towards mental health among Muslim Bangladeshi service users and their carers in the UK (Dein, 2010). Using focus groups and narrative-based interviews, it was found that participants had

Western and cultural psychosocial explanations for events (e.g. *izzat*, loss of social honour, spirit possession). Similarly, an ethnographic study within a Muslim Bangladeshi community in the UK found that spirit possession explanations were usually used during times of acute stress and when physiological symptoms were unexplainable (Dein et al., 2008). Both studies found participants frequently turned to spiritual healers, with the elderly being more readily accepting and younger generations more sceptical of *jinns* as explanations for psychological distress. Studies have also shown that mental illnesses can be viewed as an indication of detachment or punishment from God (Al-Krenawi & Graham, 1999) or a lack of devotion (Weatherhead & Daiches, 2010). These findings highlight the importance of religion in the causal attributions of distress and illness for Muslims.

The transient nature of this life also forms an important belief, "awareness that this life is a preparation for the… hereafter" (Akhir, 2008, p. 38). This provides a sense of meaning and purpose for believers beyond this life. Therefore, distress for Muslims, when borne with faith, can be viewed as a pathway for a better life in the hereafter. Belief in God's will, patience, and turning to God, through religious duties, are said to be both preventative and curative of distress, as well as encouraging psycho-spiritual development (Ali, Lie & Humedian, 2004; El Azayem & Hedayat-Diba, 1994). This religious commitment may provide spiritual protection during times of distress. Indeed, in the face of discrimination and Islamophobia, Muslim samples were found to utilise religion as positive coping mechanism (Abuzahra, 2004; Beitin, 2003; Beitin & Allen, 2005; Jasperse et al., 2012).

#### 2.4.4. Islam and appraisals

Given the fundamental Islamic assumption of divine will and the integral nature of faith in the lives of Muslims, Islam is expected to have an impact on appraisals throughout a believer's life. Consequently, such appraisals, in line with Ehlers and Clarke's (2000) PTSD model, should have an impact on the worldview, coping strategies and mental health of Muslims.

Indeed, Berzengi et al's (2017) study demonstrates the significant interaction between trauma trauma-related appraisals, Islamic appraisals, religious coping and PTSD symptoms. Research has also demonstrated that psychological distress is experienced when Muslim individuals distance themselves from or behave in ways that contradict their faith (Smither & Khorsandi, 2009). Therefore, researchers within the Psychology of Islam have emphasised the necessity to develop present knowledge and understanding of the manner through which Islam impacts the cognitions and behaviours related to various psychological conditions (Ali et al., 2004; Erickson & Al-Timimi, 2001).

Islam provides a structured framework that influences adherents behaviours, attitudes and identity going beyond the spiritual domain and influencing daily life (Armstrong, 1993; El Azayem & Hedayat-Diba, 1994; Hamdan, 2007). It provides several explanatory models for psychological distress and traditional methods of healing and coping. The next section examines the existing literature on the impact of Islam on the world assumptions and trauma appraisals of Muslim refugees/asylum seekers.

## 2.5. Focused literature review on Islam, trauma appraisals and world assumptions among Muslim refugees/asylum seekers.

### 2.5.1 Objective and procedure

The literature search targeted references related to Islam and worldviews, trauma appraisals and coping strategies of Muslim refugees/asylum seekers. Appraisal was defined as an individual's evaluation of the origins of, accountability for, and future consequences of the trauma (Brewin & Holmes, 2003). Trauma was defined as exposure to at least one event within the DSM-5 PTSD criterion A (APA, 2013). The inclusion criterion for the review was studies using adult populations and those published within English language peer-reviewed journals. Publication date constraints were not applied.

The following electronic databases were used to identify relevant studies: PsycINFO, PubMed, ASSIA, Web of Science, JSTOR, and Google Scholar. The subsequent Boolean variable string was utilised in the search: (Islam* OR Muslim*) AND (PTSD OR posttraumatic stress disorder OR post-traumatic stress disorder OR trauma* OR stress*) AND (appraisal OR interpret* OR coping OR cope OR cognitive*) AND (identity OR identification) AND (Worldview OR World assumptions) AND (refugee* OR asylum seeker*). To determine whether studies met the inclusion criteria, all results were assessed at either title, abstract, or by reading the full paper.

2.5.2. Results

The search initially yielded 292 studies. Studies were excluded if they did not explore religiosity, trauma appraisals or use a Muslim adult sample. Studies with mixed religious samples were included. Twenty-seven studies were identified and included in this review. Table 1 below outlines general study characteristics (design, sample characteristics, sampling) and pertinent findings. Noteworthy findings include the limited number of mixed-methods research, despite recommendations within refugee research (Tempany, 2009). Several studies using mixed religious samples were vague about specific religious affiliations (Byrskog, Olsson, Essén, Allvin, 2014; Carroll, 2004; Simmelink et al., 2013; Thomas, Roberts, Luitel, Upadhaya, & Tol, 2011; Yaser et al., 2016). Such ambiguities make it difficult to draw conclusions for Muslim participants. Also demonstrated was a scarcity of research within this domain in the UK, with only two studies being identified. Furthermore, the prevalence of convenience, purposive and snowballing sampling techniques rather than stratified sampling perhaps indicates the sampling challenges encountered with this hard-to-reach population (Sulaiman-Hill & Thompson, 2011).

Table 1: *Study characteristics and key findings*

| Study characteristics | Background | Findings on religion |
|---|---|---|
| **Ahmed, Bowen, & Feng, 2017**<br>Design: mixed-methods<br>(structured questionnaire and single focus group)<br>Sampling: purposive | 12 Syrian refugee women in Saskatoon Canada in 2015–16, who were either pregnant or 1 year post-delivery. | -Spiritual practices (e.g. prayer and Quran) reported as sources of strength and support by all women. |
| **Yaser, Slewa-Younan, Smith, Olson, Guajardo, & Mond, (2016)**<br>Design: mixed-methods (self-reported measures and interviews using clinical vignettes)<br>Sampling: convenience and snowball | Examined mental health literacy of 150 resettled Afghan refugees in South Australia.<br>-Mixed religious sample (unspecified) | -Perceived beneficial interventions for PTSD included reading Quran/ Bible, prayer (66.2%), consulting religious leaders or religious communal institutions (48%).<br>-Those with less education were more likely to perceive reading Quran and traditional healing methods as helpful than those with greater education.<br>-Older participants were more likely to perceive prayer and turning to religious leaders and communities as being helpful than younger participants. |
| **Slewa-Younan, et al. (2017)**<br>Design: qualitative (clinical interview, using culturally adapted mental health literacy survey)<br>Sampling: snowballing and convenience | Examined casual beliefs and risk factors for PTSD among 25 Iraqi and 150 Afghan refugees in Australia.<br>-Mixed religious sample: Christian (45.3%), Muslim (38.2), Mandean (16.9%). | -Casual factors for PTSD rated likely or very likely:<br>Punishment from God: Afghanis (20%), Iraqis (13.4%)<br>Problems related to destiny: Afghanis (28%), Iraqis (22.1%) |
| **Alemi, James, Cruz, Zepeda, & Racadio (2014)**<br>Design: mixed-methods systematic review | Examined peer-reviewed qualitative, quantitative, and mixed-methods studies related to the mental health of Afghan refugees between 1979-2013.<br>-17 studies identified | - Qualitative studies highlighted the most prominent help-seeking behaviours included, religion, expressions of gratitude and social support. |
| **Betancourt et al. (2015)**<br>Design: qualitative (semi-structured interviews)<br>Sampling: purposive maximum variation and snowball | -Investigated the strengths and assets used by Somali refugee children and families (total participants N=32) to deal with resettlement and acculturation challenges, in Boston, US. | -Religious faith found to be a fundamental part of cultural identity and a significant protective factors for youth and families.<br>-Religion was used to cope with past traumas. |
| **Jaranson et al. (2004)**<br>Design: quantitative study (structured questionnaires)<br>Sampling: purposive | -Examined torture, traumatic events, social, physiological and psychological problems, including PTSD among 1134 Somali and Ethiopian (Oromo) refugees in Minnesota.<br>-87% Muslim, 13% Christian | -Low scores on least 2 of the problem scales/PCL-C were correlated with maintaining religious practices since resettlement, among other factors like employment, high school graduation, marriage. |

| Study characteristics | Background | Findings on religion |
|---|---|---|
| **Siriwardhana, Ali, Roberts & Stewart (2014)**<br>Design: Systematic review study | -Reviewed qualitative and quantitative studies on the effect of resilience on the mental health of forced adult migrants from conflict regions. | -Of 23 studies reviewed, 10 studies showed that resilience was associated with having religion and a belief system among other qualities (e.g. collective identity, community, social support). |
| **Sossou, Craig, Ogren & Schnak (2008)**<br>Design: qualitative study (semi-structured interviews)<br>Sampling: purposive | -Investigated the coping mechanisms of 7 Bosnian women refugees resettled in two cities in US over 5 years. | - Coping factors facilitating resettlement included spirituality taking a non-organised religious form, family, values, social and communal support. |
| **Thomas, Roberts, Luitel, Upadhaya, & Tol (2011)**<br>Design: qualitative study (semi-structured interviews and focus groups)<br>Sampling: convenience and snowballing | -Examined coping and resilience among 16 Pakistani and 8 Somali refugees in Kathmandu, Nepal. | - Religion, family and friendship provided emotional support facilitating confidence.<br>-The therapeutic role of prayer was reported. Religion and God were protective factors for suicidal ideation. |
| **Carroll (2004)**<br>Design: qualitative study (semi-structured interviews)<br>Sampling: convenience and snowballing | -Examined understanding, expressions and treatment of mental illness and service utilisation among 17 Somali refugees in New York. | -Three culturally specific types of mental health issues were identified, which were related to certain behaviours and treatment approaches:<br>1. murug: sadness or suffering<br>2. jinn: madness caused by spirit possession<br>3. waali: madness caused by extreme trauma<br>-Preferred interventions included family, prayer and traditional healing methods. |
| **Byrskog, Olsson, Essén & Allvin (2014)**<br>Design: Qualitative study (semi-structured interviews)<br>Sampling: purposive | -Explored experiences of war, violence, and reproductive health among 17 Somali refugee women in Sweden. | -Faith was a survival strategy within a war context along with social networks, patience.<br>-Findings on religion were somewhat contradictory, with religion augmenting women's difficulties in attaining autonomy especially when connected with power (e.g. abortion laws being described as unlawful within Islam) but simultaneously religion contributed to individual resilience.<br>-'moving on' and endurance were significant coping mechanisms, deriving from cultural and religious traditions.<br>-Endurance was associated with intrinsic abilities and trust in God's plans, providing a source of acceptance and hope. |
| **Anjum, Nordqvist & Timpka (2012)**<br>Design: Qualitative longitudinal study<br>Sample: convenience (refugees) and stratified (professionals) | -Investigated hopeful thinking among 56 adult West African refugees at arrival in Sweden and 6 years later. These were compared to the perspectives of resettlement support professionals 3 years after refugee arrival.<br>-Christians (57.1%) and Muslims (35.7% | - Support professionals reported that religious activities and church membership were related to greater hope. |

| Study characteristics | Background | Findings on religion |
|---|---|---|
| **Buber-Ennser et al. (2016)**<br>Design: qualitative (semi-structured interviews)<br>Sampling: convenience | -Examined socio-demographic factors and human capital, attitudes and values among 52 refugees from Syria, Iraq and Afghanistan resettled in Austria<br>-Most participants identified as Muslim | -Religion had a significant impact on attitudes.<br>-Findings demonstrate that among more religious male participants, gender-egalitarian perspectives exists.<br>-20% of participants reported being not religious, 11% reported being very religious.<br>-Females were more likely to rate themselves as religious than males.<br>-Those identifying as very religious decreases with education. |
| **Teunissen et al., 2004**<br>Design: qualitative study (semi structured interviews)<br>Sampling: purposive | -Examined health-seeking behaviours of 15 undocumented migrants across 4 cities in the Netherlands<br>-Predominantly Muslim sample | -All participants used religion and religious practices as significant positive coping mechanisms to manage mental distress.<br>-No negative religious coping was reported.<br>-Participants reported turning to friends and religions first, with GPs being their last option. |
| **Papadopoulos, Lees, Lay & Gebrehiwot, (2004)**<br>Design: qualitative study (semi structured interview and questionnaire)<br>Sampling: quota and snowballing | -Examined the migration experiences, adaptation, resettlement in the UK and health beliefs and practices of 106 Ethiopian refugees and asylum seekers<br>-Mixed religious sample: 55% Orthodox Christians, 35% Other Christians, 8% Muslims, 2% Jehovah's Witnesses. | -Most participants attributed mental illness to supernatural (God, Satan or evil spirits, magic, evil eye) and psychosocial causes.<br>-Religious beliefs and practices provided them with hope, guidance, continuity, familiarity, and spiritual support in adapting to British culture. |
| **Adedoyin et al. (2016)**<br>Design: systematic review study | -Systematic review of literature on religious coping among African refugees resettled in the US. | -Religious practices (private and communal) were used to cope traumatic experiences. |
| **Valtonen (1998)**<br>Design: qualitative study (semi-structured interviews)<br>Sampling: purposive | -Examined the assimilation process of 29 refugees from Iran, Iraq and Kuwait resettled in Finland in 1994<br>-no data provided on religious affiliation | -Religion offered meaning for events beyond individual control.<br>-The mosque symbolized an anchor for social and psychological distress, particularly in early resettlement. It provided religious education, various forms of non-material support (e.g. counselling in family problems), which took precedence over practical settlement assistance.<br>-Religion provided refugees with a constant in continually changing context and provided a connection between their home and host country. |
| **Simmelink, Lightfoot, Dube, Blevins, & Lum (2013)**<br>Design: qualitative study (focus groups)<br>Sample: purposive, key informants within community | -Examined perceptions, ideas and beliefs about health and healthcare of East-African refugees among 15 participants including East-African community leaders and healthcare professionals in the US. | -Religion, Islam and Christianity, offered coping strategies for illness experiences. Strategies included praying, reading Quran, speaking to the Imam, which was said to reduce stress and anxiety.<br>-Significance of placing health in God's hands, and God determining health and coping through trust in God were highlighted. |

| Study characteristics | Background | Findings on religion |
|---|---|---|
| **Lightfoot, Blevins, Lum & Dube (2016)**<br>Design: Qualitative study (semi-structured interviews)<br>Sampling: convenience, snowball | -Examined cultural assets of 49 Somali and 27 Oromo refugees in Minnesota.<br>-Most Somali participants were Muslims. | -Significance of religious beliefs as cultural health assets were demonstrated.<br>-Religion was a source of pride and information, through religious gatherings and leaders.<br>-Religious and cultural practices were key assets in organising daily life. Islam providing health values and coping strategies was discussed, including rules around hygiene, mind-altering substances, encouraging hard work, exercise and healthy eating.<br>-Traditional medication included certain foods often used in combination with reading Quran. |
| **Khawaja, White, Schweitzer, & Greenslade (2008)**<br>Design: qualitative study (semi-structured interviews)<br>Sampling: purposive | -Explored premigration, transit and postmigration experiences of Sudanese refugees resettled in Australia.<br>-22 Christians, 1 Muslim | -Main coping strategies were religious beliefs<br>-Premigration and transition phase religious coping strategies reported included placing fate in God's hands, trusting in Gods's will, praying for a better future.<br>-Transition phase religious coping was through the religious communities e.g. church attendance, facilitating social and emotional support. |
| **Ai, Peterson, & Huang (2003)**<br>Design: quantitative study (self-report measures)<br>Sampling: convenience | -Examined religiosity, war-related trauma, religious-spiritual coping, optimism, and hope in 138 Bosnian and Kosovan refugees in Michigan and Washington states.<br>-Predominant Muslim sample | -Muslim refugees utilised positive religious–spiritual coping significantly more than negative religious coping.<br>-Optimism was found to be positively associated with positive religious coping, which was consequently correlated with greater religiosity and higher education<br>-Hope was positively correlated with education, and negatively correlated with negative religious coping, which consequently predicted more severe trauma. |
| **Vujcich (2007)**<br>Design: qualitative study (interviews)<br>Sampling: snowball | -Examined the relationship between war, religion and migration in 10 Bosnian Muslim resettled in Western Australia. | -Participants placed more prominence on Islam during the Balkan conflict.<br>-Islam was used to make sense of the atrocities during war, provide a sense of justice (if not in this life in the next) and coping mechanisms e.g. praying for protection (e.g. God is the protector)<br>-Expressions of religiosity upon resettlement were dependent on pre-migration religiosity and post-migration interaction with other Muslims. |

| Study characteristics | Background | Findings on religion |
|---|---|---|
| **Warfa, Curtis, Watters, Carswell, Ingleby & Bhui, (2012)**<br>Design: mixed methods (focus groups and structured questionnaires)<br>Sampling: convenience | -Examined the social and environmental context of Somali refugees in the US and UK between 2001-2005. | -Somalis felt especially disadvantaged as they were not only refugees but also Muslim, black and frequently considered as difficult to integrate. |
| **Groen, Richters, Laban, & Devillé, (2017)**<br>Design: qualitative study (brief version of the cultural interview)<br>Sampling: purposive | -Explored the impact of cultural identity on stress and acculturation among traumatized asylum seekers/refugees, 43 Afghan and 42 Iraqi refugee patients, with PTSD, and/or Anxiety and/or Depression Disorder<br>-Data collected from February 2006-April 2011 in US.<br>-Predominantly Muslim sample with 6 Christians | -Ethno-religious issues from pre-migration stressors were significant in potentially traumatic events of many participants, which is contrary to general cultural identity, creating fear and in some cases conversion in host countries. Afghanis reported violence against Hazaras and Shiites, whereas in violence in Iraq was directed towards ethnic minorities i.e. Suniis and Christians. |
| **Colic-Peisker (2005)**<br>Design: qualitative interviews (semi-structured interviews)<br>Sample: purposive | -Examined the impact of race and social inclusion among Bosnian refugees resettled in Perth and Sydney between 2001-2003.<br>-No demographic data given about participants. | -Most Bosniak refugees did not identify with Australian Muslims and tended to see themselves in the cultural context of Europe rather in the context of Islamic Ummah<br>-Muslim identity had internal than external significance, and was a way to distinguish them from Croatians and Serbs, with most participants expressing secular views on Islam.<br>-Negative associations attached to the Muslim identity did not seem to impact participants due to their racial invisibility in the Australian context. |
| **Colic-Peisker (2009)**<br>Design: mixed-methods (structured questionnaire and semi-structured interview)<br>Sample: snowball and purposive | -Explored the settlement experiences of 150 ex-Yugoslavs, black Africans and Middle Eastern refugees resettled in Australia<br>-no data on religiosity | -Reports described discrimination due to Muslim identity e.g. name, appearance, or dress in the case of women (among the Middle Eastern respondents) and 'black skin' (among Africans). |
| **Hasan, Mitschke & Ravi (2018)**<br>Design: qualitative (semi-structured interviews)<br>Sampling: snowball | -Examined the role of the Islamic faith in influencing resilience in 10 Syrian refugees recently resettled in US. | -Being Muslim found to be an integral part of identity, providing comfort, strength, pride, and humbleness. |

2.5.3. Positive religious appraisals and coping

Only two studies directly examined the impact of religiosity on trauma among Muslim refugee samples, Vujcich (2007), and Ai et al. (2003), with the latter specifically measuring religious coping. Nevertheless, most studies demonstrate that Muslim refugee samples utilised religion as a positive coping mechanism through spiritual practices like prayer (e.g. praying for protection), placing trust/fate in God, reading Quran, and turning to religious leaders and communities (Ahmed, Bowen, & Feng, 2017; Byrskog, Olsson, Essén & Allvin, 2014; Simmelink, Lightfoot, Dube, Blevins, & Lum, 2013; Teunissen et al., 2004; Thomas, Roberts, Luitel, Upadhaya, & Tol, 2011; Valtonen, 1998; Yaser et al., 2016). Religion was found to provide participants with a source of strength and support, emotional/therapeutic support, hope, familiarity and continuity (Papadopoulos, Lees, Lay, & Gebrehiwot, 2004), meaning and justice (Valtonen, 1998; Vujcich, 2007), and be a protective factor against suicidal ideation (Thomas, Roberts, Luitel, Upadhaya, & Tol, 2011) and past traumas (Betancourt et al., 2015).

Religion was also found to impact mental health. Yaser et al.'s (2016) findings highlight that religion was a coping mechanism and a beneficial PTSD intervention. Some interesting findings reported were that older participants were more likely to perceive prayer and turning to religious leaders and communities as being helpful than younger participants. Those with less education were more likely to perceive Quranic recitation and traditional healing methods as more helpful than those with greater education. Similarly, participants within Wright et al's, (2017) study expressed that religion was a protective factor against PTSD in kidnapping narratives, despite most being kidnapped for religious reasons. Within Jaranson et al's (2004) study, low scores on least two of the problem scales/PCL-C since resettlement were correlated with maintaining religious practices, among other factors like employment and marriage. Additionally, Simmelink

et al. (2013) found that participants utilised positive religious coping to reduce stress and anxiety.

Ai et al. (2003) reported that Muslim refugees utilised positive religious–spiritual coping significantly more than negative religious coping. Specifically, optimism was found to be positively associated with positive religious coping, which was consequently correlated with greater religiosity and higher education. Vujcich's (2007) study demonstrated that participants placed more prominence on Islam during the Balkan conflict. Likewise, Byrskog et al. (2014) found that faith was a survival strategy within a war context along with social support and stoicism. Findings on religion were somewhat contradictory, with religion augmenting women's difficulties in attaining autonomy especially when connected with power (e.g. abortion laws being described as unlawful within Islam), simultaneously, religion was found to contribute to individual resilience. 'Moving on' and endurance were found be valued coping mechanisms among women, with their origins being rooted in both cultural and religious traditions. Endurance was associated with both intrinsic abilities and trust in God's plans, which provided a source of acceptance and hope.

Additionally, Lightfoot et al. (2016) reported that religious beliefs were cultural health assets, with religion being a source of pride and health information, disseminated through religious congregations, leaders and oral traditions. Participants expressed how Islamic values encouraged a healthy lifestyle, with rules around eating, exercise, hard work and traditional medication including certain foods in combination with Quranic verses. Within Teunissen et al.'s (2004) study, participants reported turning to religion and friends first for help-seeking, with GPs being their last option. Similarly, Carroll (2004) demonstrated that preferred interventions for mental health included prayer, family and traditional healing methods. Valtonen (1998) found that the

mosque symbolised an anchor during social and psychological distress, particularly during early post-migration. Mosques provided religious education, and various forms of non-material support (e.g. counselling for family problems). Religion seemed to provide participants with a constant in a continually changing context and also a connection between their home and host country.

Findings from systematic reviews also demonstrate religion to be a significant coping mechanism for Muslim refugees. Alemi et al. (2014) found that significant help-seeking behaviours among certain Afghan refugee subgroups included religion, expressions of gratitude and social support. Within 10 of 23 studies reviewed, Siriwardhana et al. (2014) found that resilience was associated with having a religion among other qualities like possessing a collective identity, community, social and family support and cohesion. Adedoyin et al. (2016) found that religious beliefs were practiced by African refugees resettled in the USA, and were used in coping with traumatic experiences. Specifically, four articles implicated organized religious activities in coping with trauma experienced by African refugees (Clarke & Borders, 2014; Clarkson Freeman, Penney, Bettmann & Lecy, 2013; Ellis et al., 2010; Isakson & Jurkovic, 2013) and five articles identified private religious activities as coping mechanisms for trauma (Bentley, Ahmad & Thoburn, 2014; Jaranson et al., 2004; Leaman & Gee, 2012; Simmerlink, et al 2013; Weine et al., 2011).

2.5.4. Negative religious appraisals

Only two studies were found that demonstrated negative religious coping among Muslim refugee samples. Slewa-Younan, et al. (2017) found that in attributing causal factors for PTSD, 20% of Afghanis and 13.4% of Iraqis rated punishment from God and 28% of Afghanis and 22.1% of Iraqis rated problems related to destiny, as being likely or very likely. Within Ai et al.'s (2003)

study, hope was found to be negatively correlated with negative religious coping, which consequently predicted greater severity in trauma responses.

### 2.5.5. Islam as an explanatory model for illness

Three studies identified aspects of Islam as explanatory models for mental health. Carroll (2004) reported three culturally specific types of mental health issues related to certain behaviours and treatment approaches among Somali refugees: *murug*, sadness or suffering, *jinn*, madness caused by spirit possession, *waali*, madness caused by extreme trauma. Traditional methods of healing were preferred like prayer and turning to family. Similarly, within Papadopoulos et al.'s (2004) study, most participants attributed mental illness to supernatural (God, Satan or evil spirits, magic, the evil eye) and psychosocial causes.

### 2.5.6. Islam and identity

Islam was also found to impact identity among Muslim refugee samples. Hasan et al.'s (2018) study on the role of Islamic faith as a resilience factor among Syrian refugees found that identifying as a Muslim was an integral part of their identity, which functioned as a means of security, strength, pride and humbleness. Betancourt et al. (2015) found that religious faith was a fundamental part of cultural identity. Buber-Ennser et al. (2016) also found that religion had a significant impact on attitudes. Contrary to popular belief, more religious male participants were found to have gender-egalitarian perspectives and only 11% of participants reported being very religious. Vujcich (2007) found that expressions of religiosity upon resettlement were dependent on pre-migration religiosity and post-migration interaction with other Muslims. Specifically, those with low-level pre-migration Islamic knowledge were likely to internalise the values and ideas of more conservative Muslims on arriving in Australia. Those with well-developed pre-

migration knowledge of Islam were likely to persist with their initial beliefs and practices and challenge external influences.

Religious identity was also shown to have negative implications for Muslim refugees. Colic-Peisker (2009) reported that participants described discrimination due to their Muslim identity, for instance, name, appearance, or dress code for women (among the Middle Eastern respondents) and 'black skin' (among Africans). Refugees, however, reported street discrimination as being hostile but insignificant for their lives and expressed moving forward quickly. Furthermore, narratives demonstrate that participants were aware of their own internalised perceptions of discriminations, for example, participants blamed their hijab rather than racist prejudice for discrimination experienced.

Within Warfa et al.'s (2012) study, Somali participants reported feeling especially disadvantaged in host nations, as they were not only refugees/asylum seekers but also Muslim, black, and frequently considered difficult to integrate. Narratives and experiences of certain participants suggest integration experiences of Somali refugees do not readily fit into existing acculturation models, as models concentrate on the individual's identification with the host culture and not the social and legal barriers which hinder effective integration. Groen et al. (2017) found that ethno-religious issues from pre-migration stressors significantly impacted potentially traumatic events of many participants. For example, Afghanis reported violence against Hazaras and Shiites, whereas in Iraq, violence was directed towards ethnic minorities like Suniis and Christians. Fear of religious groups continued in host countries but to a lesser extent. In most cases fear lead to avoidance of those from other ethno-religious groups, with some participants reporting conversions to Christianity.

Studies also demonstrate that Islam impacts identity in ways that are unique to individuals. Palmer (2009) found that participants interpreted Islam in a variety of ways, which was demonstrated, for instance, through their diversity in dress code and views regarding modesty and physicality. This seemed to create continually fluctuating tensions, which the women had to negotiate, between different cultural identities as women of Muslim Somali/Ethiopian communities, and as women growing up in an Australian community. The theme of being culturally 'out of place', between both the Islamic culture and general Australian culture, was prevalent within narratives. Contrastingly, research among Bosnian refugee samples demonstrates that most Bosniak refugees do not identify with Australian Muslims and tend to see themselves in the cultural context of Europe rather in the Islamic *ummah* (Colic-Peisker, 2005). For many Bosniaks, their Muslim identity had internal rather than external significance, a way to distinguish them from Croatians and Serbs, with most participants expressing secular views on Islam. Furthermore, negative associations attached to their Muslim identity did not seem to impact participants due to their racial invisibility in the Australian context.

Findings from the literature review suggest that Islam plays an important role in self-perceptions, explanatory beliefs and coping mechanisms of Muslim refugees/asylum seekers. Several studies reported the common theme of God's will, with religion being viewed as both the cause and solution for trauma and many participants utilising religious coping.

## 2.6. Rationale

Despite the importance of trauma-related appraisals and coping mechanisms in the onset, maintenance and treatment of PTSD (Ehlers & Clark, 2000; Jobson, 2009) and the prevalence of PTSD in non-Western populations and specifically refugees/asylum seekers, there remains a dearth of knowledge and understanding on maintenance and treatments factors among such

populations (Foa et al., 2009). The limited literature available demonstrates that Islam plays an important role in trauma appraisals and coping mechanisms among Muslim trauma survivors generally (Aflakesir & Coleman, 2009; Berzengi et al., 2017) and refugees/asylum seekers specifically (Ahmed, Bowen, & Feng, 2017; Ai, Peterson and Huang, 2003). Given the centrality of appraisals within PTSD and the impact of Islam on Muslim perceptions of the self and world, research within this area seems essential.

In the face of the current refugee crisis, with most refugees/asylum seekers coming from predominantly Muslim regions, there seem to be several gaps within the literature on Islam and its impact on trauma. Firstly, despite the centrality of world assumptions and trauma appraisals within PTSD, to the researcher's knowledge, there have been no studies investigating the impact of Islam on the world assumptions of Muslim trauma survivors or refugees/asylum seekers. Furthermore, research on world assumptions and trauma (Zukermann & Korn, 2014) has utilised the World Assumptions Scale, a measure with several psychometric issues (Kaler et al., 2008). Secondly, existing research on trauma and religion among Muslim trauma survivors and refugees (Ai, Peterson & Huang, 2003) seem to use generic measures of religiosity like RCope (Pargament et al., 1998). To the researcher's knowledge, there have been no studies utilising specific Islamic measures of religiosity in examining the relationship between religiosity, coping and trauma among Muslim refugee/asylum populations. Thirdly, there is also a limited number of studies utilising mixed-methods. Finally, research on the impact of religious identification in relation to trauma within this population remains scarce. This is especially important given the current climate of Islamophobia and anti-immigration (ICIBI, 2016; Zunes, 2017).

Such limitations within the current body of research indicates that understandings of Muslim refugee/asylum seeker experiences are not specific enough. Theoretically, a greater

understanding of the impact of Islam on world assumptions, trauma appraisals and coping may elucidate refugee/asylum seeker experiences further and inform models of trauma for such a population. Clinically, such knowledge may facilitate the delivery of more culturally sensitive interventions, especially in a population reluctant to seek help (Norris & Aroian, 2008). In dealing with the refugee crisis, the WHO (2017) has mandated that a key priority of the research community is to assist in building resilience, promoting and developing mental health. Given this, it becomes important to gain a greater understanding of the impact of Islam on the world assumptions and trauma appraisals of Muslim refugees/asylum seekers.

## 2.7. Hypotheses

The following hypotheses are proposed for the quantitative study based on existing literature:

1. *Religious coping and trauma*: Given that negative religious coping has been linked to poor psychological outcomes in various populations, including Muslim trauma survivors (Aflaksier & Coleman, 2009; Berzengi, Berzenji, Kadim, Mustafa & Jobson, 2017) and positive religious coping has been linked to improved psychological outcomes in various populations, including Muslims (Abuzahra, 2004; Dein & O'Connor, 2008), it is hypothesised that:

   *$H_{1a}$: Negative religious coping will explain substantial variance in PTSD symptoms scores and have positive beta weights.*

   *$H_{1b}$: Negative religious coping will explain substantial variance in post-trauma appraisals (negative cognitions about self and world, self-blame) and have positive beta weights.*

   *$H_{2a}$: Positive religious coping will explain substantial variance in PTSD symptoms scores and have negative beta weights.*

*$H_{2b}$: Positive religious coping will explain substantial variance in post-trauma appraisals (negative cognitions about self and world, self-blame) and have negative beta weights.*

2. *Religious identification and trauma*: Given the centrality of Islam to Muslims' individual and social identities (Armstrong, 1993; El Azayem & Hedayat-Diba, 1994) and the protective role played by religion (Beitin, 2003; Jasperse et al., 2012), it is hypothesised that:

   *$H_{3a}$: Greater religious identification will explain substantial variance in PTSD symptoms and have negative beta weights.*

   *$H_{3b}$: Greater religious identification will explain substantial variance in post-trauma appraisals (negative cognitions about self and world, self-blame) and have negative beta weights.*

3. *Religious coping and world assumptions*: Research within the Jewish tradition indicates that positive religious coping is associated with more positive world assumptions and negative religious coping is associated with more negative world assumptions (Zukerman & Korn, 2014). Consequently, given the Abrahamic origins of both Islam and Judaism, it is hypothesised that:

   *$H_{4a}$: Positive religious coping will explain substantial variance in more positive world assumptions (controllability and predictability of people, controllability of events, trustworthiness and goodness of people and safety and vulnerability).*

   *$H_{4b}$: Negative religious coping will explain substantial variance in more negative world assumptions*.

4. *Religious identification and world assumptions*: Given that Islam provides a framework for its believers, encompassing the individual, society, world and future (Armstrong, 1993; Khan, 1986; Sarwar, 2000) and the centrality of God's will, it is hypothesised that:

   *$H_{5a}$: Greater religious identification will explain substantial variance in more positive world assumptions on the trustworthiness and goodness of people and safety and vulnerability subscales.*

   *$H_{5b}$: Greater religious identification will explain substantial variance in more negative world assumptions on the controllability and predictability of people and controllability of events subscales.*

The following research questions were explored in the qualitative study:

1. Is religion important for Muslim refugees and asylum seekers in understanding their life and trauma experiences?
2. Is Islam used to cope with trauma experiences? If so, how?
3. How does Islam and the Muslim identity impact trauma experiences, appraisals and worldviews during pre-migration, migration and post-migration?
4. What are perceptions of psychological support?

# 3. Methodological issues

This chapter examines methodological issues arising in the refugee/asylum seeker and religion research domains. The use of the mixed-methods approach is then described. This is followed by an exploration of the research context in working with refugees. Finally, ethical considerations are examined.

## 3.1 Methodological concerns within refugee/asylum seeker & religion research

Refugee/asylum seeker research within the mental health domain has largely focused on assessing psychiatric symptomology. Certain controversies in research using this traditional bio-medical model of trauma has been highlighted (Khawaja et al., 2008). Firstly, this approach has a limited focal point in investigating pre-migration or post-migration phases. Therefore, stressful experiences during the journey and the transient nature of experiences seem to be largely disregarded (Miller et al., 2002). Indeed, studies on refugee mental health examining diverse samples (Bogic, Njoku, & Priebe, 2015; Porter & Haslam, 2005) demonstrate the difficulties experienced extends beyond the pre-migration phase into the transitional phase. This highlights the need for greater research spanning throughout refugee/asylum seeker experience, pre-migration, migration and post-migration.

Secondly, the biomedical trauma model is inadequate in explaining the relatively low rates of psychiatric symptomology in post-war societies (Steel & Silove, 2001). Findings demonstrate that most refugees acclimate to their traumatic experiences (Steel, Silove, Phan, & Bauman, 2002; Vuković, Jovanović, Kolarić, Vidović, & Mollica, 2014). This is in accordance with humanistic and existential models of trauma, which emphasise individual and communal coping capabilities in the face of mass violence and forced migration (Steel & Silove, 2001). Kira, Amer and Wrobel (2014) underline the importance of using multisystemic ecological models in the

treatment of Arab refugees, as wellbeing extends beyond an individual level to a familial, societal and religious level. They also emphasise the need for longitudinal and mixed-methods research among Arab refugees. This highlights the importance of looking beyond symptomology and examining the resilience factors. The biomedical trauma model underestimates the resilience of humans to reconstruct their worldviews and adapt to emerging situations. Nevertheless, it is beneficial in framing issues and providing an objective basis for analysis.

Research within the domain of religion and mental health has also highlighted controversies. While a largely positive relationship is demonstrated between religion and mental health, the necessity for more complex methodology is highlighted (Dein, Cook, & Koenig, 2012). It is also acknowledged that most research within this domain derives from Christian traditions, which calls for clearer discrimination between different cultures and attention to specific experiences of individuals belonging to distinct traditions. Furthermore, the importance of integrating mental health and theological perspectives is emphasised in addressing the needs of today's multicultural society.

## 3.2. The mixed-methods approach

Given the above considerations, this study uses a sequential mixed-methods approach, involving quantitative questionnaires and qualitative interviews, which "in combination provides a better understanding of research problems than either approach alone." (Creswell & Clark, 2007, p. 5). The scarcity of research within the Islam-trauma-refugee/asylum seeker domain caused the researcher to use questionnaires to gain information about areas of importance to further examine. Quantitative research, with a nomothetic approach, outlines general behavioural patterns for a large sample, given its primary aim is theory testing. It does not, however, provide a detailed picture of research questions (Curry, Nembhard & Bradley, 2009; Morrow, 2007;

Ponterotto, 2005). Qualitative research, conversely, with an ideographic and emic approach, focusing on the uniqueness of the individual, is concerned with meanings that an individual attributes to a particular phenomenon (Barlow & Nock, 2009).

A mixed-method approach is also complementary with the social justice ethos of Counselling Psychology (Kennedy & Arthur, 2014), as it bring into focus the socio-cultural beliefs of this group through empirical and experiential perspectives. Therefore, researchers have argued that it is valuable in cross-cultural investigations (Church & Katigbak, 2002; Diaz-Loving, 2005; Kim & Berry, 1993).

3.2.1. Paradigm debate

Paradigms are said to be fundamental for any scientific domain (Kuhn, 1970). It is defined as "systems of beliefs and practices that influence how researchers select both questions they study and methods used to study them" (Morgan, 2007, p.47). Paradigms are constructed through specific features: firstly, epistemology, the theory of knowledge, including method, validity, scope and the distinction between justified beliefs and opinions (Hamlyn, 1995). The researcher hopes that the knowledge gathered from questionnaires and interviews represents true beliefs and perceptions of Muslim refugee/asylum seeker participants. Secondly, ontology, "the study of being" (Crotty, 2009, p.10), encompasses perceptions of reality. This research seeks to gain insight into the realities of Muslim refugee/asylum seeker participants and their experience of trauma and religion. Thirdly, axiology, "what human states are to be valued simply because of what they are" (Heron & Reason, 1997, p.287). This includes values important to participants and the researcher. As a scientist-practitioner, this research is guided by the BPS ethical guidelines (2009). The researcher also acknowledges her own beliefs, values and biases influencing this process (Chapter 7). Fourthly, methodology, a "plan of action, process or design

lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes" (Crotty, 2009, p.3). Data was gathered in this study through survey questionnaires and semi-structured interviews.

One issue fundamental to the paradigm debate is the best paradigm issue, which attempts to establish the most appropriate philosophical paradigm for mixed-methods research. The mixed-methods approach is criticised predominantly on the incompatibility premises. This argues that quantitative and qualitative research methods and paradigms are incompatible, given their varying ontological and epistemological positions (Bryman, 2006; Doyle, Brady & Byrne, 2009). There are also those who argue that varying paradigms and methods are compatible. Within the pragmatist approach, paradigms can be combined. This forms the foundational framework for the mixed-methods approach. Hailed as the "philosophy of common sense" (Shields, 1998, p. 197), it employs several ideologies, utilising "what works" (Creswell & Clark, 2010, p. 43) and valuing subjective and objective knowledge. Furthermore, it posits that the 'best fit' issue should concern the research question itself rather than the paradigm or theoretical foundations (Scott & Briggs, 2009). This affords the researcher greater freedom in examining their research questions. The pragmatic approach is practically oriented, with findings being seen within a practical context, rather than being influenced by certain ideologies and their roots as in paradigm-focused research. Consequently, the pragmatic approach is seen to be compatible with mixed-methods research.

3.2.2. Sequence of methodologies

Within this sequential explanatory design, Phase 1, the quantitative study, examined if religious coping and identification explained substantial variance in trauma symptoms, appraisals and world assumptions (Creswell & Zhang, 2009). These findings formed the basis for questions

within semi-structured interviews in Phase 2, the qualitative study, which further explored and expanded on findings from Phase 1. Once both sets of data were collected and analysed, interpretations from both phases were compared, contrasted and combined (Creswell, 2009; Creswell & Planto Clark, 2010). This leads to data triangulation, where an integration of different data sets and perspectives provides greater insight into the subject of inquiry (Fielding, 2012).

## 3.3. Research context: Participant recruitment and setting

Participant recruitment took place between April 2017 and July 2018. Several refugee centre leads in the Midlands and Northern England were initially contacted. Three centres agreed for the study to be conducted, in East, West Midlands, and Northern England. Meetings were arranged with centre leads to address questions and concerns, review measures and discuss study logistics. Initially, centre volunteers helped the researcher identify potential participants. After gaining familiarity with centres, the researcher approached participants for recruitment for Phase 1. For Phase 2, the researcher sought guidance on participant recruitment from centre volunteers, to identify those willing and able to share their experiences. Participants identified were then approached by the researcher, who provided them with an information sheet and addressed any questions or concerns before requesting consent to take part in the study.

### 3.3.1. Considerations when working with refugees/asylum seekers

The study aimed to address a number of considerations specifically pertaining to working with refugees/asylum seekers (Patel et al., 2018). These included respect, accessibility, boundaries and considerations in working with interpreters. The researcher attempted to foster a mutually respectful relationship with refugee centres. This required assuming a collaborative perspective, where the researcher, in acknowledging the expertise of staff at refugee centres, some of whom

were refugees themselves, sought to learn from them about working with this population. Furthermore, given the sensitive nature of the research topic, participants were treated with respect, which included ensuring their comfort during participation, both physically (e.g. seating in a private area) and emotionally (e.g. asking participants if they wanted to take a break or stop), and following participation (section 3.4.5).

Accessibility was considered especially for participants in the qualitative phase. Participants were met and interviewed at familiar locations (e.g. the refugee centre) and on a day and time of their convenience. Prior to the interview, travel directions were provided, along with an appointment card containing the researcher's professional contact information. Furthermore, participants were asked about special requirements (e.g. interpreters, physical needs), questions or concerns, which the researcher attempted to fulfil to the best of her ability. The researcher also familiarised herself with the socio-political context of the participants' country of origin. With regards to boundaries, the researcher aimed to help within a professional capacity rather than personal one e.g. sign posting to relevant organisations.

One participant required an interpreter. Given the significance of language as an 'investigative and therapeutic tool' (Farooq & Fear, 2003, p.104), several considerations were considered in the selection process (Tribe & Thompson, 2008). This included someone who was familiar to the participant through the refugee centre, matched for gender, religious and cultural background and able to work in sensitive and reliable manner. In developing a working relationship and ensuring the reliability of questions asked, the researcher met with the interpreter several times prior to the interview to outline the research objective, method and general approach. This included clarification of terminology used, to ensure the essence of certain phrases (e.g. to cope) were captured within Arabic interpretations. Given the small language community, prior to the

interview itself, confidentiality issues were discussed with the interpreter and participant. The researcher sought to create a comfortable interview atmosphere, through the positioning of seats, maintaining eye contact with both the interpreter and participant and pacing communications (Razban, 2003). Furthermore, a review of the interview process was carried out with both the participant and interpreter, to ensure the emotional wellbeing of both parties (Baylav, 2003; Darroch & Dempsey, 2016). This involved examining how individuals found the interview and any difficulties encountered during the process.

## 3.4. Ethical considerations

### 3.4.1. Ethical approval

Ethical approval for the study was gained from the Faculty of Education, Health and Wellbeing Ethics Committee at the University of Wolverhampton (Appendix 2).

### 3.4.2. Informed consent

Informed consent was gained in line with BPS (2014) guidelines, which ensured that participants were able make an informed decision regarding their choice to take part in the study. Participants were approached individually to ask if they would like to participate in the study. Interested individuals were provided with an information sheet (Appendix 3), which contained key details of study and addressed issues like confidentiality, withdrawal rights and data storage. After reading this, potential participants were given the opportunity to ask questions. If they agreed to participate, they were given a consent sheet to complete. The voluntary nature of the study and the right of withdrawal at any point without providing a reason was also made explicit in both phases of the study. Anonymity was highlighted to participants in both phases with identifying features not being obtained (Phase 1) or removed (Phase 2). Furthermore, it was emphasised that

questionnaires or recording would be given back to participants or deleted in front of them, should they wish to withdraw.

The researcher acknowledged certain power dynamics that might influence coercion. There was potential for participants to feel obliged to participate if refugee centre volunteers approached individuals. To minimise this, volunteers were asked only to direct the researcher towards potential participants. They were not present when the information sheet was given, consent was gained or during the course of the study. Participants were also informed that their decision regarding participation would have no bearing on their immigration status and that their individual responses would not be fed back to the refugee centre or any government organisations.

### 3.4.3. Confidentiality

Considering the sensitive nature of refugee/asylum experiences, confidentiality was emphasised. Participants were explicitly told not to write names on the questionnaire booklets. Each booklet was given a unique numerical code for identification and stored in a separate envelope from consent forms, which contained participants' names. For Phase 2, participants were informed that the identifying features, like names, would be removed from the transcript.

### 3.4.4. Data storage

Completed questionnaires were stored in line with the Data Protection Act (2018) and General Data Protection Regulation (2018). Booklets were kept in a locked cabinet only accessible by the researcher. In both phases, raw data was entered into the researcher's password-protected laptop, only accessible by her. This used only unique numerical codes for participants and did not contain any identifiable features like names. Consent forms and questionnaires booklets were

stored in separate cabinets. In accordance with University of Wolverhampton data management policy (2018), data will be retained for a minimum of 10 years from collection.

### 3.4.5. Managing distress

Certain questions that participants answered had the potential to be distressing, given that they addressed past trauma. Potential risks were addressed in the following ways. Firstly, potential participants were informed at the outset that the study asked about the potentially distressing events. Secondly, participants were informed at the outset of their right to withdraw at any point without providing a reason. Thirdly, participants were debriefed in both phases. This involved checking their wellbeing by asking how they felt and if they were experiencing any distress. Participants were also provided with a debriefing sheet. This specified contact details of the researcher, should they want to discuss the study further or if they were experiencing any distress and contact information of external counselling organisations.

# 4. Quantitative study

This section examines the quantitative phase. The design, sampling method, measures, procedure and data analysis are outlined. The quantitative results are presented and a discussion is offered.

## 4.1. Method

### 4.1.1. Design

A cross-sectional correlational design was used to investigate the relationship between religious coping, identification and PTSD symptoms, trauma appraisals and world assumptions. Independent variables included, religious identification, positive religious coping, negative religious coping and religious struggle. Dependent variables included, trauma symptoms, post-trauma appraisals (negative perception of self, world and self-blame), and world assumptions (controllability of events, controllability and predictability of people, trustworthiness and goodness of people, safety and vulnerability).

### 4.1.2. Participants

#### *4.1.2.1. Sampling*

Convenience and snowball sampling were used to recruit participants. Inclusion criteria were Muslim refugees or asylum seekers post-Arab spring, over 18 years, English or Arabic speaking from Middle-Eastern or North and Sub-Saharan African regions and with experience of at least one traumatic event, defined by DSM-5 PTSD Criterion A (APA, 2013). Participants were recruited from these regions, given that these are where refugee/asylum applicants are mostly granted (Home Office, 2017). Arabic is the most widely spoken language within these regions. Therefore, participants who spoke Arabic or English were recruited. In attempting to curtail sample heterogeneity due to cultural differences, Arabic speaking Muslims from other regions, like South Asia or Iran were excluded.

Based on effect sizes from previous research (Berzengi et al., 2017; Engelbrecht & Jobson, 2014) and in the absence of research between Post-trauma Cognitions Inventory (PTCI; Foa et al., 1999), PTSD symptoms and religious coping in Muslim refugees/asylum seekers, a medium effect size was assumed. A priori power calculations were conducted for research questions using G*Power 3 (Faul, Erdfelder, Lang & Buchner, 2007). For a multiple regression test ($R^2$ deviation from zero), with a medium effect size of $f^2 = .15$, error probability (α) of .05, power of 0.80 (Cohen, 1988), and 4 predictor variables, a minimum sample size of 85 participants was recommended.

*4.1.2.2. Demographic information*

Eighty-four participants were included in the study. Seventy-four were male (88.1%) and 10 were female (11.9%). Participants were aged between 20-44 years (M= 29.03, SD= 6.41). Sixty-eight participants completed questionnaires in Arabic (81%) and 16 in English (19%). Table 2 outlines key participant characteristics.

Table 2.

*Key participant characteristics*

| | Frequency | Percentage (%) |
|---|---|---|
| **Immigration status** | | |
| Refugee | 45 | 53.6 |
| Asylum seeker | 39 | 46.4 |
| **Marital status** | | |
| Single | 47 | 56 |
| Married | 33 | 39.3 |
| Divorced/ Separated | 3 | 3.6 |
| Widowed | 1 | 1.2 |
| **Country of Origin** | | |
| Sudan | 43 | 51.2 |
| Syria | 16 | 19 |
| Iraq | 8 | 9.5 |
| Libya | 3 | 3.6 |
| Eritrea | 4 | 4.8 |
| Ethiopia | 4 | 4.8 |
| Somalia | 4 | 4.8 |
| Stateless | 2 | 2.4 |
| **Education** | | |
| Primary school | 27 | 32.1 |
| Secondary school | 42 | 50 |
| Higher education | 15 | 17.9 |
| **Religious Sect** | | |
| Sunni | 82 | 97.6 |
| Shiia | 2 | 2.4 |

## 4.2. Materials: Questionnaire booklet

Translation: Questionnaire booklets were offered in both English and Arabic (Appendix 3a, 3b). The information sheet, consent form, instruments and debriefing sheet were translated into Arabic (Appendix 3b). A back-translation method was used, as described by Brislin, Lonner, and Thorndike (1973) and recommended by cross-cultural researchers (Brislin, 1970; Champman & Carter, 1979). This method is outlined in figure 3. The questionnaire was piloted on a small

sample thought to be representative of the study population to assess comprehensibility (N=3). This included one participant fluent in both English and Arabic, another who only spoke Arabic and another with basic knowledge of English. The piloting seemed successful, with feedback from participants suggesting that measures were comprehensible, whilst acknowledging that questions were difficult to answer concisely and categorically.

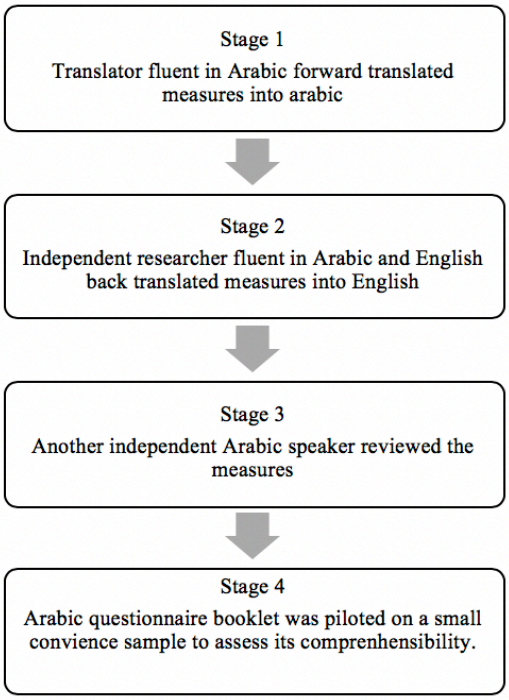


*Figure 3*: Back-translation process of questionnaires booklets adapted from Brislin et al. (1973).

Demographics: Demographic information collected included age, gender (male/female/other), marital status (single, married/in a relationship, divorced, widowed), country of origin, education (primary school, secondary/high school, higher education, other), religious sect (Sunni/Shia/other), immigration status (refugee/asylum seeker), month/year they left their home country.

PTSD Symptoms*: PTSD Checklist-5 (PCL-5; Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013)*

PCL-5 is a 20-item self-report measure, assessing 20 symptoms of PTSD in accordance with the DSM-5. It can be used as a screening, provisional diagnostic tool or to monitor change in PTSD symptoms. It has a total score range of 0-80 and asks about the degree to which individuals are bothered by each of the DSM-5 PTSD symptoms on a five-point scale (0=Not at all to 4=Extremely). PCL-5 has demonstrated strong psychometric properties (Bovin et al., 2016) and excellent internal consistency α = 0.90-95 (Armour, Fried, Deserno, Tsai, & Pietrzak, 2017; Maheux, & Price, 2016).

Post-trauma appraisals: *Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999)*

PTCI is a 33-item self-report measure used to assess trauma-related cognitions and beliefs. It is concerned with negative cognitive trauma-related appraisals, representative of individuals with PTSD; negative self, negative world, and self-blame. Items are rated on a 7-point scale (1 = "totally disagree" to 7 = "totally agree"). PTCI is shown to be a valid and reliable measure, discriminating between those with and without PTSD. It is found to have adequate psychometric properties, excellent internal consistency α = 0.93 (Beck et al, 2004; Müller et al., 2010) and re-test reliability (rs = .74; Foa et al., 1999). It has also been used in several cross-cultural studies (Diehle, de Roos, Meiser-Stedman, Boer & Lindauer, 2015; Engelbrecht, & Jobson, 2014).

World assumptions: *The World Assumptions Questionnaire (WAQ; Kaler, 2009)*

WAQ is a 22-item measure assessing fundamental assumptions individuals have about the world. It consists of four subscales: Controllability of Events (CE), Comprehensibility and Predictability of People (CPP), Trust-worthiness and Goodness of People (TGP), and Safety and Vulnerability (SV). Items are measured on a 6-point Likert scale (1=strongly agree to 6=

strongly disagree). WAQ is shown to have good psychometric properties, including good internal consistency (α = .74 to .82), high temporal stability coefficients for scores on each subscale (range: .68–.74; Mean *r* = .70) and construct validity (Anders, Frazier & Shallcross, 2014; Kaler, 2009; Schuler & Boals, 2016). It has also been used in cross-cultural research (Freh, Chung, & Dallos, 2013).

Islamic Religious Coping*: Psychological Measure of Islamic Religiousness (PMIR; Abu Raiya, Pargament, Mahoney, & Stein, 2008)*

PMIR is a 60-item measure, consisting of seven dimensions with independent scales. The scales examined in this study were: religious identification (five items), positive religious coping (seven items), negative religious coping (three items) and religious struggle (six items). The PMIR demonstrates strong psychometric properties. All scales are shown to have high internal consistency ranging between α = .77 and .97. Subscales are shown to have discriminant, convergent, concurrent, and incremental validity. It has also been used in cross-cultural research (Ghorbani, Watson, Geranmayepour, & Chen, 2014; Khan, Watson, Chen, Iftikhar, & Jabeen, 2012).

Social Desirability: *Social Desirability Scale-Short Form (SDS-SF; Reynolds, 1982)*

SDS-SF is a 13-item scale, assessing the social desirability bias. Participants rate statements as either true or false. SDS-SF has shown good internal consistency α= .76 and concurrent validity in several countries (Putnick et al., 2014). This scale was used as research shows that Muslims may be inclined to portray Islam and their religiousness in a good light (Abu-Raiya & Pargament, 2011; Amer et al., 2008).

#### 4.2.1. Procedure

The researcher was present throughout the study, from recruitment to the completion of questionnaires and debriefing. Interested individuals were taken to a quiet room, where they read the information sheet and were given an opportunity to ask questions. Upon agreeing to participate, a consent form was provided to be signed, prior to the questionnaire administration. Measures were administered in the following order: demographic questions, PCL-5, PTCI, PMRI, WAQ, and SDS-SF. The researcher was present to answer any questions that arose during the completion of the questionnaire. Upon completion, participants were debriefed.

#### 4.2.2. Data analysis

Data was analysed using statistical software SPSS version 25 (IBM Corp, 2017). Multiple regression was used to assess if religious coping (negative, positive and religious struggle) and religious identification explained substantial variance in trauma symptoms, appraisals and world assumptions. Correlation and regression analyses were used to examine the relationship between trauma symptoms and trauma appraisals, and trauma symptoms and world assumptions.

### 4.3. Results

#### 4.3.1. Preliminary analysis

Data was pooled, each scale was summed and entered into SPSS. Only the WAQ used negative scoring. Negatively-keyed items in this scale were reverse scored before being entered into SPSS. A number of preliminary analyses were conducted before hypotheses were tested. These are outlined below.

##### *4.3.1.1. Identifying outliers*

In detecting outliers, boxplots were produced on SPSS for each variable. Unusual values were examined against questionnaires to eliminate data entry errors. Several extreme outliers were

detected among three variables (Appendix 5). Religious identification plots demonstrated 4 cases with scores significantly lower than other participants. Religious struggle plots indicated 7 cases that were significantly higher than other participants. Positive religious coping plots indicated 1 case with a significantly lower score. These outliers were removed for those variables specifically. Such scores, while untypical for the current sample, may demonstrate the variability in beliefs found when examining a complex construct like religion (Storm, 2012).

*4.3.1.2. Missing data*

There were six cases of missing data on the social desirability scale. Given the small number of missing cases and its simplicity, listwise deletion was used to handle missing data, which SPSS uses by default (Pigott, 2001). There were no incidences of missing data on other scales as the researcher, present throughout the completion of every questionnaire, pointed out questions that may have been accidently missed by participants. Approximately 12 questionnaires were not included in the dataset as participants were unable to complete them either due to personal time constraints or difficulties in understanding.

*4.3.1.3. Assumptions testing*

The reliability and validity, along with skewness and kurtosis of scales were assessed (Table 3). These indicated that the data was normally distributed (Kim, 2013). Cronbach's Alpha demonstrated good internal consistency, with most scales exceeding the benchmark value of $\alpha = .70$ (Field, 2009).

Table 3.

*Means, standard deviations, reliability, skewness and kurtosis of scales*

| | *M* | *SD* | Skewness | Kurtosis | α |
|---|---|---|---|---|---|
| **WAQ** | 36.571 | 9.854 | -0.005 | -0.561 | 0.771 |
| **PCTI** | 97.810 | 35.218 | 0.470 | -0.559 | 0.925 |
| **PCL** | 31.902 | 17.041 | 0.513 | -0.936 | 0.901 |
| **PMIR (religious identification)** | 18.500 | 2.239 | -1.666 | 2.00 | 0.763 |
| **PMIR (positive religious coping)** | 26.40 | 2.503 | -1.589 | 1.372 | 0.147 |
| **PMIR (negative religious coping)** | 7.100 | 3.600 | -0.103 | -1.260 | 0.839 |
| **PMIR (religious struggle)** | 1.870 | 2.302 | 1.259 | 1.153 | 0.905 |
| **Social desirability** | 7.845 | 2.91 | -0.777 | 0.510 | 0.854 |

Tests of multicollinearity demonstrated no issues as tolerance values were great than 0.1 (Menard, 1995) and VIF values were less than 10 (Myers & Myers 1990) (Table 4).

Table 4.

*Tests of multicollinearity for predictor variables*

| Variables | Positive religious coping | Negative religious coping | Religious struggle | Religious identification |
|---|---|---|---|---|
| **Positive religious coping** | | . | | |
| Tolerance | | .694 | .845 | .765 |
| VIF | | 1.441 | 1.183 | 1.306 |
| **Negative religious coping** | | | | |
| Tolerance | .952 | | .990 | .918 |
| VIF | 1.050 | | 1.010 | 1.090 |
| **Religious struggle** | | | | |
| Tolerance | .929 | .794 | | .732 |
| VIF | 1.076 | 1.260 | | 1.366 |
| **Religious identification** | | | | |
| Tolerance | .974 | .852 | .847 | |
| VIF | 1.027 | 1.174 | 1.180 | |

The homoscedasticity of data was also assessed using a visual inspection of scatter plots (Appendix 6), which suggested that the assumption was met for all variables.

*Use of effect sizes*: Effect size within regression is a simple measure of difference between two groups, which has several benefits over the use of tests focused solely on statistical significance (Wilkinson, 1999). Effect sizes highlight the size of differences instead of confounding this with

sample size. Furthermore, “statistical significance does not imply meaningfulness” (Olejnik & Algina, 2004, p. 241), while effect sizes focuses on meaningfulness (Fan, 2001). Given this and the small sample size in this study, the section below pays particular attention to effect sizes over statistical significance, utilising Cohen’s (1988) guidelines.

*4.3.1.4. Exploratory analyses on participant characteristics*

Independent samples *t*-test were conducted to examine whether scores on the main study variables were significantly different across various participate characteristics. A significant difference was found between those responding to the questionnaire in Arabic and English with regards to trauma symptoms. Specifically, participants responding to the Arabic questionnaire reported significantly greater trauma symptoms than those responding in English. A significant difference was also found between questionnaire language and WAQ CPP, TGP and SV (Table 5). This indicated that those responding to the English questionnaire perceived significantly greater CPP, TGP and SV than Arabic counterparts.

Table 5.

*Comparison of questionnaire language on trauma symptoms and world assumptions*

| Variables | | Arabic | English | *t* | *df* | *p* | *SE* |
|---|---|---|---|---|---|---|---|
| **Trauma symptoms** | M | 32.76 | 23.25 | 2.94 | 41.65 | .01 | 3.23 |
| | SD | (17.62) | (9.7) | | | | |
| **WAQ CPP** | M | 11.35 | 14.25 | -2.22 | 82 | .03 | 1.30 |
| | SD | (4.86) | (3.82) | | | | |
| **WAQ TGP** | M | 15.90 | 19.44 | -2.394 | 82 | .02 | 1.48 |
| | SD | (5.43) | (4.83) | | | | |
| **WAQ SV** | M | 14.13 | 18.88 | -3.0 | 18.45 | .01 | 1.58 |
| | SD | (4.11) | (6.0) | | | | |

Additionally, a significant difference was found between immigration status, refugees and asylum seekers, with regards to PTCI self-blame and WAQ CE (Table 6). This indicated that asylum seeker participants were significantly more likely to engage in self-blame about trauma appraisals than refugees. They were also found to perceive significantly greater CE than refugees.

Table 6.

*Comparison of immigration status on trauma appraisals and world assumptions*

| Variables | | Refugee | Asylum seeker | *t* | *df* | *p* | *SE* |
|---|---|---|---|---|---|---|---|
| **PTCI self-blame** | M<br>SD | 2.57<br>(1.34) | 3.15<br>(1.34) | -2.13 | 82 | .04 | .27 |
| **WAQ CE** | M<br>SD | 11.64<br>(3.64) | 14.10<br>(4.90) | -2.63 | 82 | .01 | .93 |

*4.3.1.5. Exploratory analyses on world assumptions, trauma appraisals and trauma symptoms*

WAQ CE, CPP and TGP, were found to significantly negatively correlate with trauma symptoms (Table 7). This indicates that the greater CE, CPP and TGP perceived, the fewer trauma symptoms reported. Multiple regression was conducted to investigate if the model was significant. This demonstrated that world assumptions significantly predicted trauma symptoms ($R^2$= .228, $F$(4, 79)= 5.849, $p$< .001). Specifically, TGP was found to significantly negatively predict trauma symptoms. This indicates that the greater TGP perceived, the fewer trauma symptoms reported. CE, CPP and SV, were found to be non-significant predictors.

Table 7.

*Summary of multiple regression examining the variance explained by world assumptions on trauma symptoms*

| **Variables** | ***B*** | ***SE B*** | ***β*** | **Partial correlations** |
|---|---|---|---|---|
| **Constant** | 55.378 | 6.719 | | |
| **WAQ CE** | -.276 | .437 | -.073 | -.071 |
| **WAQ CPP** | -.403 | .475 | -.115 | -.095 |
| **WAQ TGP** | -1.309 | .369 | -.426** | -.371 |
| **WAQ SV** | .372 | .438 | .108 | .095 |

*$p < .05$, **$p < .01$, and ***$p < .001$

PTCI negative perception of self and the world were found to significantly positively correlate with trauma symptoms (Table 8). This indicates that the more negative perceptions of self and world, the more trauma symptoms reported. Multiple regression was conducted to investigate if the model was significant, this demonstrated that trauma appraisals significantly predicted trauma symptoms ($R^2$= .244, $F(3, 80)$= 8.621, $p$< .001). Specifically, negative perception of self was found to significantly positively predict and self-blame was found to significantly negatively predict trauma symptoms. Interestingly, negative perception of the world did not to significantly predict trauma symptoms. Therefore, the model indicates that those with greater negative perception of self, report more trauma symptoms. Those engaging in greater self-blame reported less trauma symptoms.

Table 8.

*Summary of multiple regression examining the variance explained by trauma appraisals on trauma symptoms*

| **Variables** | ***B*** | ***SE B*** | ***β*** | **Partial correlations** |
|---|---|---|---|---|
| **Constant** | 12.029 | 5.162 | | |
| **Negative cognitions about self** | 9.681 | 2.258 | .656*** | .430 |
| **Negative cognitions about the world** | .1557 | 1.250 | .135 | .138 |
| **Self-blame** | -4.876 | 2.045 | -.366* | -.257 |

*$p < .05$, **$p < .01$, and ***$p < .001$

*4.3.1.6. Exploratory analyses on social desirability*

Exploratory analyses on social desirability and positive religious coping ($r(83) = .157$, $p = .155$), negative religious coping ($r(84) = -.173$, $p = .115$), religious struggle ($r(77) = -.133$, $p = .248$) and religious identification ($r(80) = -.120$, $p = .289$) revealed no significant correlations. This suggests that social desirability did not influence religious variables.

4.3.2. Hypothesis testing

Multiple regression analyses were conducted as this study wanted to predict trauma symptoms, trauma appraisals and world assumptions based on four predictor variables, religious coping (positive, negative and struggle) and religious identification.

*4.3.2.1. The effect of religious coping and identification on trauma*

4.3.2.1.1. Trauma symptoms

Multiple regression was conducted to investigate whether religious coping and identification predicted trauma symptoms as measured by PCL scores. Results indicated that the while the model was a non-significant predictor of trauma symptoms, it had a small effect size ($R^2$= 0.034, $F$(4, 69)= .613, $p$=.655). The analysis showed that neither positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted trauma symptoms (Table 9). Therefore, the following hypotheses were not supported:

$H_{1a}$: Negative religious coping will explain substantial variance in PTSD symptoms scores and have positive beta weights.

$H_{2a}$: Positive religious coping will explain substantial variance in PTSD symptoms scores and have negative beta weights.

$H_{3a}$: Greater religious identification will explain substantial variance in PTSD symptoms and have negative beta weights.

Table 9.

*Summary of multiple regression examining the variance explained by religious coping and identification on trauma symptoms*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | -.554 | .996 | -.081 |
| Negative religious coping | -.323 | .580 | -.069 |
| Religious struggle | .895 | 1.111 | .111 |
| Religious identification | 1.038 | 1.020 | 0.131 |

*$p < .05$, **$p < .01$, and ***$p < .001$

4.3.2.1.2. Trauma appraisals

Multiple regression was also conducted to investigate whether religious coping and identification predicted post-trauma appraisals (negative cognitions about self, world, self-blame) measured by PTCI.

*Negative cognitions about self:* Results indicated that the while the model was a not significant predictor of negative cognitions about self, it had a small effect size ($R^2$= 0.057, $F$(4, 69)= 1.036, $p$= .395). The analysis showed that neither positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted PTCI negative cognitions about self (Table 10).

Table 10.

*Summary of multiple regression examining the variance explained by religious coping and identification on PCTI negative cognitions about self*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | .048 | .068 | .102 |
| Negative religious coping | .006 | .039 | .019 |
| Religious struggle | .140 | .076 | .253 |
| Religious identification | .031 | .069 | .057 |

*$p < .05$, **$p < .01$, and ***$p < .001$

*Negative cognitions about the world*: Results indicated that the while the model was a not significant predictor of negative cognitions about the world, it had a small effect size ($R^2 = .016$, $F(4, 69) = .284$, $p = .888$). The analysis showed that neither positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted PTCI negative cognitions about the world (Table 11).

Table 11.

*Summary of multiple regression examining the variance explained by religious coping and identification on PCTI negative cognitions about world*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | .022 | .087 | .036 |
| Negative religious coping | -.011 | .051 | -.028 |
| Religious struggle | .033 | .098 | .047 |
| Religious identification | -.088 | .090 | -.127 |

*$p < .05$, **$p < .01$, and ***$p < .001$

*Self-blame:* Results indicated that the while the model was a non-significant predictor of self-blame, it had a small effect size ($R^2$=0.034, $F(4, 69)= .612$, $p= .655$). The analysis showed that positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted PTCI self-blame (Table 12).

Table 12.

*Summary of multiple regression examining the variance explained by religious coping and identification on PCTI self-blame*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | .093 | .076 | .178 |
| Negative religious coping | -.012 | .044 | -.034 |
| Religious struggle | .117 | .084 | .192 |
| Religious identification | -.007 | .077 | -.011 |

*$p < .05$, **$p < .01$, and ***$p < .001$

Therefore, the following hypotheses were not supported:

*$H_{1b}$:* Negative religious coping will explain substantial variance in post-trauma appraisals (negative cognitions about self and world, self-blame) and have positive beta weights.

*$H_{2b}$:*Positive religious coping will explain substantial variance in post-trauma appraisals (negative cognitions about self and world, self-blame) and have negative beta weights.

*$H_{3b}$:* Greater religious identification will explain substantial variance post-trauma appraisals (negative cognitions about self and world, self-blame) and have negative beta weights.

*4.3.2.2. The effect of religious coping and identification on world assumptions*

Multiple regression was also conducted to investigate whether religious coping (positive religious coping, negative religious coping and religious struggle) and religious identification predicted world assumptions (CE, CPP, TGP and SV) measured by the WAQ.

CE: Results indicated that the while the model was a non-significant predictor of CE, it had a small effect size ($R^2$=.071, $F(4, 69)$= 1.314, $p$= .274). The analysis showed that neither positive

religious coping, negative religious coping, religious struggle nor religious identification significantly predicted WAQ CE (Table 13).

Table 13.

*Summary of multiple regression examining the variance explained by religious coping and identification on WAQ controllability of event*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | -.072 | .259 | - .084 |
| Negative religious coping | .231 | .147 | .191 |
| Religious struggle | .195 | .282 | .094 |
| Religious identification | -.173 | .259 | -.084 |

*$p < .05$, **$p < .01$, and ***$p < .001$

CPP: Results indicated that the while the model was a non-significant predictor of CPP, it had a small effect size ($R^2$=0.016, $F(4, 69)$= .285, $p$= .886). The analysis showed that neither positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted WAQ CPP (Table 14).

Table 14.

*Summary of multiple regression examining the variance explained by religious coping and identification on WAQ controllability and predictability of people*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | -.071 | .289 | -.036 |
| Negative religious coping | .063 | 0.168 | .047 |
| Religious struggle | -.118 | .322 | -.051 |
| Religious identification | -.244 | .295 | -.107 |

*$p < .05$, **$p < .01$, and ***$p < .001$

*TGP:* Results indicated that the while the model was a non-significant predictor of TGP, it had a small effect size ($R^2$=0.050, $F(4, 69)$= .915, $p$= .460). The analysis showed that neither positive religious coping, negative religious coping, religious struggle nor religious identification were significant predictors of WAQ TGP (Table 15).

Table 15.

*Summary of multiple regression examining the variance explained by religious coping and identification on WAQ trustworthiness and goodness of people*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | .205 | .306 | .096 |
| Negative religious coping | .182 | .178 | .125 |
| Religious struggle | -.324 | .342 | -.130 |
| Religious identification | -.311 | .314 | -.126 |

*$p < .05$, **$p < .01$, and ***$p < .001$

*SV:* Results indicated that the while the model was a non-significant predictor of SV, it had a small effect size ($R^2$=0.010, $F(4, 69)$= .168, $p$= .954). The analysis showed that neither positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted WAQ SV (Table 16).

Table 16.

*Summary of multiple regression examining the variance explained by religious coping and identification on WAQ safety and vulnerability*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | -.068 | .302 | -.033 |
| Negative religious coping | -.032 | .175 | -.023 |
| Religious struggle | -.134 | .336 | -.056 |
| Religious identification | -.178 | .306 | -.075 |

*$p < .05$, **$p < .01$, and ***$p < .001$

The above results indicate that the following hypotheses were not supported:

*$H_{4a}$: Positive religious coping will explain substantial variance in more positive world assumptions (CPP, CE, TGP, SV).*

*$H_{4b}$: Negative religious coping will explain substantial variance in more negative world assumptions*.

*$H_{5a}$: Greater religious identification will explain substantial variance in more positive world assumptions on the TGP and SV subscales.*

*$H_{5b}$: Greater religious identification will explain substantial variance in more negative world assumptions on the CPP and CE subscales.*

## 4.4. Discussion: quantitative findings

Quantitative findings indicate that religious coping (positive, negative and religious struggle) and identification did not account for substantial variance in trauma symptoms, appraisals (negative perception of self, world and self-blame) or world assumptions (controllability of events [CE], controllability and predictability of people [CPP], trustworthiness and goodness of people [TGP] and safety and vulnerability[SV]). Therefore, none of the study's hypotheses were supported. Key findings from the quantitative study are summarised in Table 17.

Table 17.

*Summary of key quantitative findings*

| Variables | Analysis | Results |
|---|---|---|
| *Exploratory analysis* | | |
| Questionnaire language and trauma symptoms | *t*-test | -A significant difference was found between those responding to the questionnaire in Arabic and English with regards to trauma symptoms. Participants responding to the Arabic questionnaire reported significantly greater trauma symptoms than those responding in English. |
| Questionnaire language and WAQ CPP, TGP, SV | *t*-test | -A significant difference was also found between questionnaire language and WAQ CPP, TGP and SV. Participants responding to the English questionnaire perceived significantly greater CPP, TGP and SV than Arabic counterparts. |
| Immigration status and PTCI self-blame | *t*-test | -A significant difference was found between immigration status, refugees and asylum seekers, with regards to PTCI self-blame. Asylum seeker participants were significantly more likely to engage in self-blame trauma appraisals than refugees. |
| Immigration status and WAQ CE | *t*-test | -A significant difference was found between immigration status, refugees and asylum seekers, with regards to WAQ CE. Asylum seeker participants were found to perceive significantly greater CE than refugees. |
| World assumptions and trauma symptoms | Multiple regression | -World assumptions significantly predicted trauma symptoms, with TGP significantly negatively predicting trauma symptoms. |
| Trauma appraisals and trauma symptoms | Multiple regression | -Trauma appraisals significantly predicted trauma symptoms. Negative perception of self was found to significantly positively predict trauma symptoms. Self-blame was found to significantly negatively predict trauma symptoms. |
| *Hypothesis testing* | | |
| Religious coping, religious identification and trauma symptoms | Multiple regression | -Neither positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted trauma symptoms. |
| Religious coping, religious identification and trauma appraisals (negative cognitions of self, world and self-blame) | Multiple regression | -Neither positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted PTCI negative cognitions about self, world and self-blame. |
| Religious coping, religious identification and world assumptions (CE, CPP, TGP and SV) | Multiple regression | -Neither positive religious coping, negative religious coping, religious struggle nor religious identification significantly predicted WAQ CE, CPP, TGP and SV. |

Quantitative results appear to support existing literature. The non-significant findings between religious coping, trauma symptoms, post-trauma cognitions and world assumptions seem to support other studies demonstrating non-significant correlations between positive religious coping and psychological wellbeing (Braam et al., 2010; Hebert et al., 2009) and negative religious coping and psychological distress, for instance, among Middle Eastern university students (Gardner, Krägeloh & Henning, 2014).

Current findings also seem to support the Shattered Assumption Theory (Janoff-Bulman, 1992) and the Cognitive Model of PTSD (Ehlers & Clark, 2000). Shattered Assumptions Theory proposes that traumas challenge central underlying assumptions, damaging an individual's worldview. These beliefs about self, world and other, within Ehlers and Clark's (2000) Model, are said to be fundamental to the development and maintenance of PTSD. Findings from this study indicate that not only were assumptions like CE, CPP and TGP found to be significantly negatively correlated with trauma symptoms but that the model was predictive of trauma symptoms, with TGP being the only significant negative predictor. Such findings support research demonstrating that traumas can shatter trust in people (Kelley et al., 2012; Martin et al., 2013) and create crisis of faith in the goodness of people (Andrews et al., 2000). No correlation, however, was found between SV and trauma symptoms. This may reflect the transient and uncertain nature of the refugee/asylum seeker experience. Even within the post-migratory phase, there appears to be a constant sense of vulnerability and insecurity, given socio-economic, social interpersonal and acculturation difficulties plus immigration-related stressors (LeMaster et al., 2017; Li et al., 2016). This ambiguity may have been reflected in participant responses to questions regarding their safety and vulnerability.

Current findings add further support to Ehlers and Clarke's (2000) PTSD Model in highlighting the role of trauma appraisals and its impact on trauma symptoms. Specifically, findings demonstrated that not only were negative perceptions of self and world significantly positively correlated with trauma symptoms but a multiple regression model found trauma appraisals to significantly predict trauma symptoms, with negative perceptions of self found to significantly positively correlate with trauma symptoms. This supports cross-sectional (Agar et al., 2006; Laposa, & Alden, 2003) and longitudinal research (Ehring et al., 2008; O'Donnell et al., 2007) demonstrating significant positive correlations between negative appraisals and PTSD symptom severity. Specifically, this study supports research demonstrating that negative appraisals about the self are more pertinent to PTSD than negative appraisals about the world or self-blame (Gomez De La Cuesta, 2017). This study also seems to partially support Berzengi et al.'s (2017) study on Islamic appraisals, trauma-related appraisals, and religious coping among Muslim trauma survivors residing in the UK and northern Iraq. Here, negative trauma-related appraisals were significantly associated with and predictive of PTSD symptoms.

The present study also found that self-blame was significantly negatively predictive of trauma symptoms. This does not support the Cognitive Model, where negative appraisals of one's trauma are shown to maintain symptoms and hinder recovery (Dunmore et al., 2001; Halligan et al., 2003). Current findings also do not support research indicating that those engaging in self-blame displayed greater PTSD symptoms (Joseph et al., 1991; Joseph et al., 1993). This could potentially demonstrate a complex relationship between the individual and their role within a collective culture. Research among trauma survivors from collectivist cultures, has demonstrated that the group and one's interrelatedness with the group was key to trauma appraisals, with the traumatized self being a secondary aspect of trauma implications (Engelbrecht & Jobson, 2016).

Therefore, participants may have found it easier to blame oneself than God or the community, thereby preserving faith in religion and the community, which facilitates the maintenance of psychological wellbeing. Nevertheless, these findings demonstrate the importance of maladaptive appraisals for trauma symptoms.

Quantitative findings do not seem to support Religious Coping Theory (Pargament et al., 1997), and literature demonstrating Muslim trauma survivors use of religious coping. For instance, Berzengi et al. (2017) found that negative religious coping distinguished between trauma survivors with and without PTSD (Study 1) and was significantly associated with PTSD symptoms (Study 2). Similarly, Aflakseir and Coleman (2009) demonstrated that religious coping significantly influenced mental health indicators including PTSD. Current findings also do not support the general literature on coping among Arab Muslims in the US following 9/11, where religion was used as a source of support and protection (Beitin, 2003; Beitin & Allen, 2005), despite religious practices predicting greater discrimination (Jasperse et al., 2012).

Specifically, quantitative findings do not seem to support the general literature on Muslim refugees and religious coping, which demonstrates that Muslim refugee samples utilise religion as a positive coping mechanism in dealing with trauma, stress and anxiety (Ahmed, et al., 2017; Byrskog et al., 2014; Simmelink et al., 2013; Teunissen et al., 2004; Thomas et al., 2011; Valtonen, 1998; Yaser et al., 2016). Current findings also do not support research among refugees demonstrating that negative religious coping, was predictive of greater trauma severity (Ai et al., 2003).

Quantitative findings do not appear to support theories like TMT and ABDT (Greenberg et al., 1986). TMT and its empirical studies demonstrate that mortality awareness results in the preservation of anxiety-buffering strategies, like cultural worldviews, integral to psychological

wellbeing (Pyszczynski & Kesebir, 2011). ABDT posits that traumas damage anxiety-buffering strategies, creating distress and resulting in PTSD symptoms (Pyszczynski & Taylor, 2016). Without such buffering mechanisms, individuals with PTSD are unable to respond to mortality reminders in the defensive way that adaptive individuals do. Current findings, with religious coping and identification being non-significant predictors of trauma (symptoms/appraisals) and world assumptions, do not demonstrate a strengthening of participants cultural worldviews (religion coping and identification), despite participants experiencing several instances of mortality salience, as predicted by TMT. Contrary to ABDT predictions, those reporting more trauma symptoms did not engage in less religious coping or identification.

Several studies on TMT and ABDT involve discrete trauma experiences, e.g. 9/11 (Pyszczynski, Greenburg & Solomon, 2003), earthquake (Abdollahi et al., 2011) and civil war (Chatard et al., 2012). It is, therefore, questioned whether the same effect of mortality salience exists among individuals, like refugees/asylum seekers, experiencing compounding traumas over extended periods. Furthermore, these theories are based on the assumption that traumas are a "fundamental assault on ... our sense of the world ... Our relationship with existence itself is shattered." (Greening, 1997, p. 125). Muslims, however, believe in the temporariness of this life and the continued existence after death, with eternal life in the hereafter (Sheikh, 1998). Challenges encountered in this life, like traumas, are said to be tests in preparation for the afterlife and part of divine will (Tayeb, Al-Zamel, Fareed & Abouellail, 2010). Therefore, death and traumas do not necessarily have negative connotations, as presumed by the above theories. These beliefs raise questions about the applicability of such theories for Muslims, whose fundamental assumptions differ from the foundational assertions of these theories.

It is acknowledged that this study only examined one of three anxiety buffering strategies, religion, and focused on certain aspects of this (religious coping and identification). It is possible that other aspects of religion and other anxiety-buffering strategies, like close personal relationships, may have played a greater role in influencing trauma response. Research has demonstrated the importance of social support and the collective identity as key coping mechanisms for this population (Siriwardhana et al., 2014). This offers an area for future research, examining the impact of other anxiety buffering strategies and aspects of cultural worldviews on Muslim refugee/asylum seekers.

The non-significance in main findings could be explained by several factors. This could suggest that religious coping and identification do not explain substantial variation in trauma symptoms, trauma appraisals and world assumptions. Individuals may be utilising coping mechanisms other than religion to deal with their trauma experiences e.g. social support, positive reappraisals or problem solving (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Research among Palestinian refugees demonstrates that psychological symptom severity varied contingent on coping style, with emotion-focused coping associated with lower distress levels soon after trauma, while problem-focused coping was associated with lower distress levels months later (Kanninen, Punamaki & Qouta, 2002). Given the post-migratory context of participants, months or years after fleeing their countries and in dealing with challenges in day-to-day living, the use of more practical problem-focused coping may be prominent compared to emotion-focused methods, like religious coping. This would support Vujcich's (2007) study, where participants were found to place greater emphasis on Islam during the Balkan conflict rather than in the resettlement phase. This is also line with Religious Coping Theory, which states that individuals tend to utilise religious coping during times of distress and within a

cultural context (Pargament et al., 1997). Therefore, religious coping may not be as prevalent in the post-migratory context, with lower levels of distress and a different cultural-religious landscape.

In terms of findings on religious identification, perhaps other identifying features played a more prominent role in trauma experiences than the Muslim identity. This is highlighted in exploratory analyses, where characteristics, like immigration status, were significantly correlated with PTCI self-blame and WAQ CE. This indicates that asylum seeker participants were significantly more likely to engage in self-blame trauma appraisals than refugees. The complexity associated with the asylum process, given its uncertain and lengthy nature (Taylor, 2009), may perhaps generate more self-blame than refugees who have greater security over their legal status. Indeed, research has demonstrated that asylum seekers fare worse on nearly all health and wellbeing measures compared to the general UK population (Taylor, 2009). This also demonstrates that identification characteristics, like immigration status, may be more pertinent to trauma responses than the Muslim identity for this sample.

Additionally, a surprising finding was that asylum seeker participants perceived significantly greater CE than refugees. It is questioned whether the greater uncertainty of the asylum process brings with it a sense of hope in a better future, which offers greater controllability, compared to the more certain fate of refugees. Research has indicated that a moderate amounts of unexpectedness, unpredictability, and uncertainty can generate a positive impact on wellbeing including hope (Wurzbach, 1992).

Exploratory findings also revealed that those answering the Arabic questionnaire reported significantly greater trauma symptoms than those answering in English. Those answering the English questionnaire were found to perceive significantly greater CPP, TGP and SV than

Arabic counterparts. Those responding in Arabic may have had less time for acculturation within the UK than their English counterparts. The acculturation process, may have provided greater CPP, TGP and SV, thereby mitigating trauma symptoms. Research demonstrates that poor host language proficiency is associated with poor mental health outcomes (Bogic et al., 2015; LeMaster et al., 2017; Li et al., 2016). The duration of participants stay in the UK was not obtained. Therefore, it is difficult to assess acculturation conclusively, which is a limitation of this research.

#### 4.4.1. Limitations of the quantitative study

In explaining these findings certain methodological limitations should be acknowledged. The small sample size may have affected the statistical power, as the study was one participant short of the minimum for a moderate effect size, which hinders extrapolation and generalisation of findings (Faber, & Fonseca, 2014). Therefore, any suggestions and implications made within this study are done so with caution. The small effect sizes found indicate that a larger sample size is needed to draw stronger conclusions about the relationship between religious coping, identification and trauma symptoms, appraisals and world assumptions. A small sample size was utilised due to difficulties with participant recruitment. Despite the researcher's efforts to gain participants through a combination of convenience and snowballing sampling methods, several issues arose during the recruitment process.

One main issue was trust. A significant factor initially was language, as the researcher did not speak Arabic (Giacco, Matanov, & Priebe, 2014). Despite the information sheet and questionnaire being available in Arabic, language seemed to create a barrier in providing an understanding of the study and gaining trust. There was a limited understanding of mental health, concerns around confidentiality, and a reluctance to engage with those outside known social

networks. Utilising volunteers from refugee centres, who spoke Arabic and could legitimise the research and researcher, in addition to snowball sampling, were ways of gaining participant trust, which aided the recruitment process. While snow-ball sampling was used to access this hard-to-reach population, issues around the impact of the first few participants on the structure of the final sample are acknowledged. This method was therefore used in combination with convenience sampling rather than alone. Furthermore, given the levels of mistrust and the power dynamics that characterise the refugee/asylum seeker experience (Hynes, 2003), the researcher spent time within refugee centres getting to know potential participants and attempting to build relationships. Despite such attempts, participant answers may have still been influenced by trust concerns, potentially creating methodological biases.

Another challenge for participant recruitment was the focus for most individuals on survival, with imminent priorities like immigration status, employment and accommodation. Consequently, many individuals did not seem to have the time or mental capacity to engage in the study. It could be argued that the context of the refugee centre, where individuals came for their survival needs, was not a conducive environment for such questionnaires, requiring individuals to reflect on their past experiences, appraisals and beliefs. Moreover, the ability for individuals to be reflective at a time where their basic needs remain unmet is questionable. This is in accordance with Maslow's (1943) hierarchy of needs and more recent functional analysis (Kenrick, Li & Butner, 2003), where physiological and safety needs and in collectivist cultures, belonging and communal needs, are required to be met before psychological needs can be addressed (Gambrel & Cianci, 2003). Therefore, participants' reflexive capacity may have been affected by their context, which may have impacted the ability to participate and in those who did, may have influenced their responses.

Results may also have been impacted by other methodological issues. While no correlation was found between social desirability and religious coping and identification, other response characteristics may have impacted results (Johnson, Kulesa, Cho, & Shavitt, 2005), especially with the research being on personal and sensitive subjects, i.e. religion and mental health. Individual items on the negative coping and religious struggle scales demonstrated floor effects (Table 3). This is consistent with previous qualitative (Harandy et al., 2010) and quantitative research (Aflaksier & Coleman, 2009; Berzengi et al., 2017) demonstrating that Muslim trauma survivors report low levels of negative religious coping and appraisals. Previous research demonstrates that Muslims consider expressing religious doubt or struggle as disrespectful to God (Amer et al., 2008) and that they have a tendency to depict Islam in a positive light (Abu-Raiya & Pargament, 2011). This is consistent with Jobson's (2009) findings on collectivist cultures, where coping strategies that serve to preserve group harmony and prevent isolation are used. Furthermore, religion among Muslims is regarded as a personal matter, with humility and discretion being encouraged in religious beliefs and actions, even for praiseworthy actions (Bukhari et al., 1956). Such considerations may have resulted in the underplaying of religious thoughts and actions, positive religious coping and religious identification, but particularly negative religious coping, struggle and identification.

Another methodological challenge resulted from conducting research among ethnic minorities, as a researcher from a different cultural context (Murray et al., 2010). Most measures were back translated into Arabic, this tried to capture as fully as possible the meaning of phrases, focusing on differences that mattered (Paegelow, 2008). While all measures demonstrated good internal consistency, it is recognised that there may have been some loss of meaning in translating from one language to another. This brings into question linguistic equivalence,

referring to the wording of items (form, meaning, structure) and ease of understanding offered through the translated form (Lonner, 1985; van de Vijver & Leung, 1997).

Furthermore, what is understood is done so within a cultural context. Therefore, conceptual equivalence is questioned, concepts and behaviours that may differ in meaning across cultures (Lonner, 1985; Poortinga & Malpass, 1986), especially with most questionnaires being developed within a Eurocentric paradigm (Douce, 2004). For instance, questions about thoughts of death may carry a different meaning within an Islamic context, where death is seen as an extension of life (Sheikh, 1998). Therefore, the cross-cultural equivalence of certain measures, like PCL-5, PTCI and WAQ, may be limited. Further research is needed to determine the conceptual and linguistic equality of these measures. The PTCI has also been criticised for being too broad and not operationalising negative appraisals as specified by the Cognitive Model of PTSD (Ehlers & Clark, 2000). This may have augmented difficulties in question interpretation and responses.

Additionally, PTCI and WAQ measures utilised Likert-type scales. Cross-cultural researchers have expressed difficulties using Likert scales among non-Western samples (Bekker, Seedat, & Stein, 2006; Lee, Jones, Mineyama & Zhang, 2002; Smit, van den Berg,). This was observed in this study, with several participants ticking relevant statements on these questionnaires, until these scales were explained. This suggests that these scales were perhaps not intuitive to the current sample. Research has demonstrated challenges in using Likert scale with low-literacy ethnic populations (Flaskerud, 2012). Most participants within the current study indicated that they received secondary school education. They, however, came from countries with varying literacy rates and education below international standards (Gatti et al., 2013). Such factors may have affected their understanding of questions and consequent responses. The above

considerations raise questions about the applicability of measures like PTCI and WAQ for this sample.

The above issues also raise questions about whether abstract concepts like religious coping, identification, trauma appraisals and world assumptions can be tested quantitatively with this sample. This maybe especially true for those coming from narrative traditions, like Middle-Eastern and African regions (Kilito, 2014; Lightfoot et al., 2016). The combination of mistrust in authorities, varying literacy/education levels may make comprehensibility difficult and allow greater susceptibility to methodological biases. Furthermore, intersectional perspectives highlight the importance of capturing the diversity of refugees/asylum seekers, rather than adopting a homogenous view of their experiences (Patel & Tribe, 2018). This emphasises the importance of a methodological approach that is able to provide a more holistic understanding of the refugee/asylum seeker experience, like a mixed-methods approach. Indeed, qualitative findings illustrate a different picture to those derived from quantitative analysis.

# 5. Qualitative study

This section examines the qualitative phase. The use of the qualitative method is outlined, followed by a description of participants, procedure and data analysis. Findings from the thematic analysis are described before a discussion is offered.

## 5.1. Qualitative Methods

In combination with the quantitative phase, the qualitative phase aimed to provide a greater understanding of research questions (Bryman, 2006). Qualitative methods are suited for studying different populations, particularly those underrepresented in mainstream psychological assessments or theory. Qualitative methods, in being less structured than quantitative methods, allow for greater flexibility and research of an exploratory nature (Jarratt, 1996). As such, it can bring to the forefront novel and unforeseen knowledge to areas of limited research (Creswell, 1998; Ponterotto, 2002).

### 5.1.1. Rationale for using semi-structured interviews

Semi-structured interviews were used as they provide a combination of predetermined areas to be discussed but also for novel and unanticipated areas to be explored (Appendix 7) . Interviews are also a natural form of enquiry, allowing participants to share their experiences (Condelli & Wrigley, 2004; Strudwick, 2010). This offers a richness of information on individual thoughts, beliefs, attitudes and behaviours (Tariq & Woodman, 2010; Teddie & Tashakkori, 2009). Similar to therapy, open-ended questions were used to gain insight into limited areas of knowledge (Robson, 2002). The process of opening communication with participants also enabled rapport and trust building.

Notwithstanding the greater methodological freedom of qualitative research and its capacity for creativity and discovery, its subjective nature holds disadvantages. The subjectivity of the

research restricts the generalisability of findings. Furthermore, the researcher's influence on the research design increases susceptibility to researcher and participant biases. It is argued that the researcher is "inextricably linked" (Yeh & Inman, 2007, p. 371) to the research and cannot be detached. This requires the researcher to reflect on biases, values and experiences that have impacted the research process and how the research process may have impacted the researcher (Thorpe, 2013; Willig, 2013).

### 5.1.2. Rationale for using Thematic Analysis

One approach to analysing qualitative data is thematic analysis. It is used "for identifying, analysing and reporting patterns within data" (Braun & Clarke, 2006, p. 79). It also offers a method for "encoding qualitative information" (Boyatzis, 1998, p. vii). Thematic analysis is considered 'contextualist' in nature (Braun & Clarke, 2006, p.81), allowing for an understanding of individual meaning-making processes and the social framework affecting this individual processing. This is appropriate for examining the role of religion on Muslim refugees/asylum seekers and trauma experiences by identifying and exploring themes, which may provide insight into this area (Fielden, Sillence & Little, 2011). Themes are said to capture "something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). Given the exploratory nature of the study, it uses an inductive approach, drawing on existing literature and the researcher's interpretation of data. Thematic analysis is utilised as a methodological tool to locate recurrent patterns in the data.

Like pragmatism, thematic analysis is not reliant on a specific epistemological position, paradigm fit, or theoretical framework instead it "matches what the researcher wants to know" (Braun & Clarke, 2006, p. 80). Therefore, it provides an adaptable research tool that can be used

within various theoretical frameworks. This adaptability allows themes within thematic analysis to be recognised in either an inductive or deductive m

anner. This qualitative study attempts to explore the possible ideas, values and beliefs that Muslim refugees/asylum seekers may have about their trauma experiences and the role of religion here.

Being theoretically unbound, unlike other methods like Interpretative Phenomenological Analysis (IPA) or discourse analysis, allows researchers to explore unintended concepts, providing a rich, in-depth and complex account of data. This flexibility can yield an 'anything goes' critique (Antaki, Billig, Edwards, & Potter, 2002), which has resulted in Braun and Clarke (2006) providing guidelines for the application of this method, such that it is 'theoretically and methodologically sound' (p. 5). They specify steps in conducting thematic analysis, these were adhered to in the present data analysis and are outlined in Table 18.

Table 18.

*Phases of thematic analysis adapted from Braun and Clarke (2006, p. 87)*

| Phase of Analysis | Description |
|---|---|
| 1. **Familiarisation with the data set** | Involves repeated reading of data in an active way, looking for meaning and patterns and making notes of initial ideas. Researchers determine themes. |
| 2. **Generating initial codes** | Involves systematically coding the entire data set. Data is formed into meaningful groups, which are then organised into themes. Additional support on coding can be gained from Coffey and Atkinson (1996). |
| 3. **Searching for Themes** | Codes are organised into meaningful groups, which are then organised into themes. The researcher considers if themes are to be analysed in an inductive (data-driven manner) or a theoretically-oriented manner (analyst-drive, motivated by the researcher's interest). Thematic maps can be used to depict the relationship between codes and themes. |
| 4. **Reviewing Themes** | This involves the checking and re-checking themes, to see if codes are linked to the coded extract and the entire data sets. Theme can be identified at a semantic (interpretation at a surface level) or latent level (interpretation of underlying notions) A thematic map is generated. |
| 5. **Defining and Naming Themes** | Themes are further refined and defined. |

## 5.2. Participants

A purposive sampling method was used to recruit six participants from an East Midlands refugee centre (Table 19). Only male participants were recruited as females approached declined. Gender disparities are explained in the discussion (section 5.6.4). The sample size is in line with recommendations from Braun and Clarke (2006). Utilising a sequential method design allowed the researcher to recruit certain participants from the quantitative study. The purposive sampling method allowed the researcher to identify individuals who had knowledge and experience (Bernard, 2002) of trauma experiences and a "willingness to participate, and the ability to communicate experiences and opinions in an articulate, expressive, and reflective manner" (Etikan, Musa & Alkassim, 2016, p. 3). The purposive strategy of maximal variation sampling was used, which aimed to recruit from as many countries within the specified region, to view research questions from various perspectives. The same inclusion criteria as the quantitative study were used.

Table 19.

*Participant demographic information*

| | Frequency | Percentage (%) |
|---|---|---|
| **Immigration status** | | |
| Refugee | 1 | 16.7 |
| Asylum seeker | 5 | 83.3 |
| **Marital status** | | |
| Single | 4 | 66.7 |
| Married | 2 | 33.3 |
| **Country of Origin** | | |
| Sudan | 2 | 33.3 |
| Syria | 1 | 16.7 |
| Somalia | 2 | 33.3 |
| Stateless | 1 | 16.7 |
| **Education** | | |
| Primary school | 1 | 16.7 |
| Secondary school | 4 | 66.7 |
| Higher education | 1 | 16.7 |
| **Religious Sect** | | |
| Sunni | 6 | 100 |

## 5.3. Procedure

The researcher approached several potential participants. Interested individuals were taken to a quiet room, where they read the information sheet and had the opportunity to ask questions (Appendix 3c). If they agreed to participate, a date and time was arranged for the interview. On the interview day, participants were once again provided with the information sheet and given the opportunity to ask questions, which were addressed. They were then given a consent form to sign. They were also asked for permission to record the interview on a digital voice recorder before the study began. The interview process took between 50 minutes and 1.5 hours. Following this, participants were debriefed. Finally, participants were asked once again if they consented for the interview data to be used in the study.

### 5.3.1. Data analysis

Data was analysed using Braun and Clarke's (2006) guidelines and Nvivo software, version 11 (QSR International, 2015). Interview recordings were uploaded onto a computer and transcribed by the researcher using an adapted version of the Silverman's syntax of conversation analysis (Gubrium & Holstein, 2002). Anonymity and confidentiality were maintained throughout this process by removing identifying features like names. Each interview was analysed separately before cross comparisons were made and themes formed. In addressing research questions at the outset of the study, this analysis focused on a few key themes arising within the data set, with a theoretically-oriented approach at a latent level. This involved making potential interpretations of underlying meanings behind themes. Key themes were included if they were prevalent across at least half the participants.

## 5.4. Research Quality

Given the subject nature of qualitative research, Lincoln and Guba (1985) argue that concepts of reliability and validity should be viewed in terms of credibility, transferability, dependability and confirmability. Threats to these impact several factors including, reactivity, the effect of the researcher's presence on participants (Lincoln & Guba, 1985), participant bias, a tendency for participants to respond in a way that the researcher wants, and researcher bias, where the researcher's assumptions influence the study's outcome (Creswell, 2013). This study attempted to address these issues in the following ways.

### 5.4.1. Credibility

Within qualitative research, credibility is defined as the value and plausibility of findings (Polit & Beck 2006). There are several methods of improving credibility, including using triangulation to validate findings. Through a mixed-methods approach, this research has used methodological

triangulation to address credibility, the use of more than one methodology in studying the same phenomenon, i.e. quantitative and qualitative approaches (Hussein, 2015). Credibility was also attempted through data saturation, "the comprehensiveness of both the data collection and analysis" Drisko (1997, p. 192). Data saturation was considered in the recruitment phase, which aimed to engage participants from different countries within the studied region, to capture as many relevant themes as possible. During data collection, after four interviews, no new themes seemed to emerge. Two more interviews were conducted to ensure data saturation was reached. Additionally, response validity or truth value was considered by presenting and discussing findings with participants, including themes and interpretations drawn from these. This resulted in the clarification and revision of certain themes, like the importance of the politicisation of Islam, which was not initially considered to an significant theme.

### 5.4.2. Confirmability & Dependability

Dependability refers to the reliability of data (Shah & Corley, 2006). Confirmability refers to the neutrality and efficiency of data (Tobin & Begley, 2004). These concepts refer to the trustworthiness of the data and can be achieved through an audit trail and reflexivity. An audit trail involves outlining decision making processes throughout the research. All decisions made throughout the study were documented and discussed with research supervisors before actions were taken. Reflexivity involves personal reflections made throughout the research process, demonstrating self-awareness (Mantzoukas, 2005). A reflective journal was kept during the qualitative study, which as suggested by previous research, contained a rationale for decisions, personal inclinations and challenges faced (Houghton, Casey, Shaw, & Murphy, 2013). This formed the basis of reflective chapter seven.

Another method used to foster dependability and confirmability was the Clean Language practice. This is a method of questioning enabling the exploration of an individual's internal world, using their own, intrinsically occurring metaphoric landscape (Lawley & Tompkins, 2000). A central feature of this practice is using the interviewee's own words and metaphors, minimising input of the interviewer's assumptions. This necessitates the interviewer to bracket their own perspective and metaphoric landscape and acknowledge that the interview will be conducted in terms of the interviewee's developing metaphors (Lawley, Meyer, Meese, Sullivan, & Tosey, 2010). Whilst Clean Language has several expansive uses, it was used here at a micro-level, as a questioning technique, to facilitate the interviewer's dependability and confirmability (Creswell, 2009).

## 5.5. Findings from thematic analysis

There were a number of themes identified, only those addressing research questions and themes found across more than half the participants were included. Given the cognitive focus of the study, the analysis examined key psychological processes involved in refugee/asylum seeker experiences.

### 5.5.1. Psychological processes

Several psychological processes are implemented in trauma processing (Brewin & Holmes, 2003). Key themes emerging from such psychological processes for participants included trauma appraisals, beliefs and coping strategies. A thematic map depicts the relationships between themes (Figure 4). These are further elaborated in sections below. This highlights the importance of Islamic beliefs in influencing trauma appraisals, world assumptions and coping strategies.

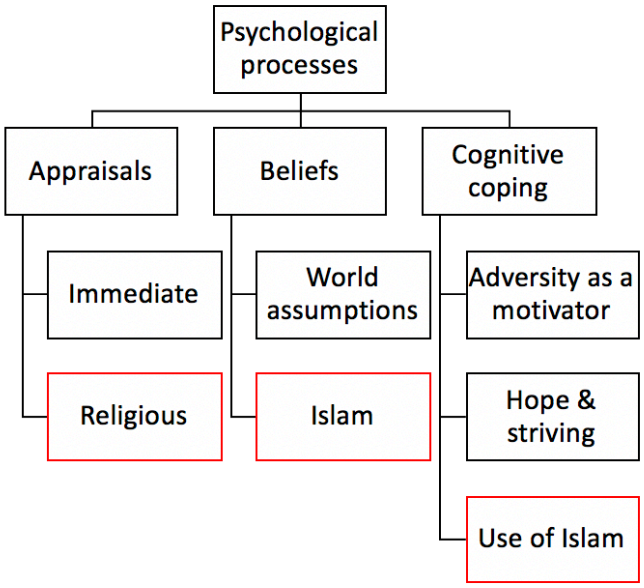


Figure 4: *Main themes*

*5.5.1.1. Trauma appraisals*

The importance of trauma appraisals is highlighted in PTSD models and interventions (Ehlers & Clark, 2000). Consequently, in examining trauma appraisals, two key themes derived included immediate trauma appraisals, retrospective evaluations during the midst of their trauma, and religious trauma appraisals.

**Immediate trauma appraisals**: In describing immediate trauma appraisals, participants expressed a sense of not being oneself. For instance, S expressed "*at that time [nobody is normal]… My mind [was absent]*". Participants reported feeling the imminence of death. S reports, "*everybody [believes that they will die]… everybody is ready to die*". They expressed a loss of control/autonomy, as M states, "[*I] was forced and it wasn't in [my hands]*".

**Religious trauma appraisals:** Participants were found to contextualise their experiences within the Islamic framework. They attributed adversities to God's will and notion of being tested. H

states, "*this is [something coming] from my God. My God wanted to examine me*". Similarly, Mo integrates the notion of life as a test and the afterlife, "*life is like [an exam]…this maybe from Islam... [you] get the result after you die".* S states, *"when they [meet problems they say] Tawakkal". Tawakkal* is an Islamic concept, which can be understood as trust/reliance on God (Leaman, 2006). S also reported that during a particularly rough boat journey at sea, the call to prayer (*adhan*) seemed to have a calming effect on the sea, which he attributed to "*Allah [creates everything]…Sea [is created by Allah]…[the sea knows Allah]".*

There was a sense of God being the controller of the universe including people's destiny. Z states, "*I'm here. I think I'm meant to be*". This is reflected in the concept of *rizq*, which signifies any means of sustenance provided by God to man, be it material or spiritual (Leaman, 2006). This is linked with one of God's names '*Al-Razzaq*', the all provider. Z reports his perspective of how God categorises *rizq* among people, *"one, God, [gives] everything and [it is easy]. Two.. they get everything, but [they] suffer a lot to get it. And third, not everything but easy… And four,… not everything, and not easy…Even one pound you suffer".*

Closely linked with God's will was an accompanying sense of gratitude or acceptance for one's situation. S states*, "[religion helps me] because when I see the problem, I say alhamdulilallah and every time I [believe] tomorrow is okay"*. *Alhamdulillah* is an Arabic phrase which can be translated to 'all praise be to Allah' (Huda, 2018).

There was also the belief in a better afterlife given adversities. Mo states, *"I have got the promise [that at last you will] find paradise"*. H also drew comparisons with the Prophet Muhammad and his own experiences, " *our Prophet Muhammad... Also he suffered… in his life in preaching his message… And also [they tried to kill him several times] and… he [migrated]".*

The above themes highlight the severity of trauma experienced and the centrality of Islamic belief to trauma appraisals for this sample.

*5.5.1.2. Beliefs*

The importance of beliefs and assumptions for trauma reactions is highlighted through theoretical models like world-view based models of trauma (Janoff-Bulman, 1992) and empirical research (Dunmore et al., 2001). In examining key beliefs, two main themes emerged Islam and world assumptions (Figure 5).

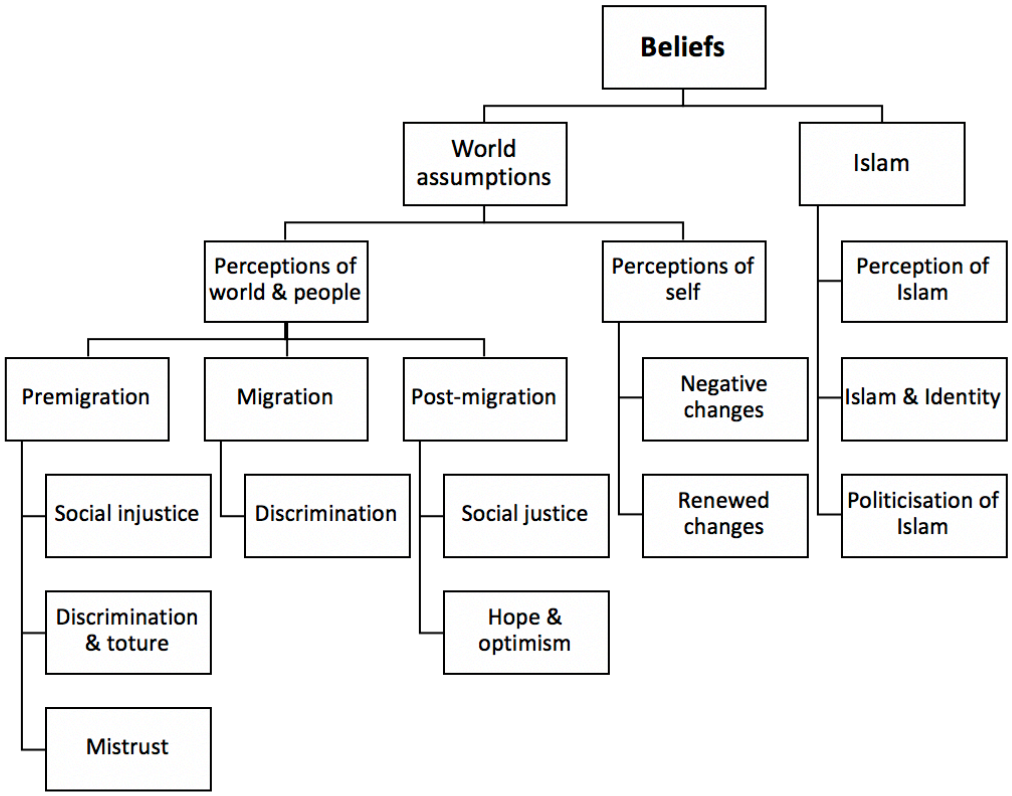


Figure 5: *Sub-themes within the main theme of beliefs*

5.5.1.2.1. Islam

**Perception of Islam**: Islam was perceived by participants to be a *"perfect"* (A), *"peaceful"* (H) and stable religion *"[I've changed]. Islam [has not]"* (Z). It was reported to be an important part of their lives, with Islam being expressed as *"my life"* (Mo), *" [dominating all aspects of my life]" (H)* and *"the way of life" (Z).* Islam was also reported to provide a framework for life,

> *I believe it [tells you how to live your life], with your wife, with your work, how to spend your money, how to [be] good with your neighbour and with my children, I think all this is from Islam… Islam [teaches] me.* (Mo)

Similarly, A states, *"It's [a perfect] religion if you [follow it][it tells you]exactly how to connect [to] the current moment, the current time, the life which we live in…[if you] apply it correctly, you will have a perfect life".*

**Islam & identity:** Islam was also shown to impact participants' identity, influencing values, attitudes and behaviours. H states, *"[never do I think one day I will do bad things like] kill or [take] revenge… because... every human Allah [created] him, [within the] universe, to develop [in] this life, not to [cause problems]".*

Islam was reported to influence values like patience. Mo states, "*Islam [taught] me really helped me [to be a ] great man because… some people shout [at] you so you don't say anything, just smile"*. Similarly, H reports, *"religion [says you] must be patient".* It was also reported to influence behaviours like helping others, as Z expresses, *"this is my understanding [of] life… if you help... you [will find others who] help you… all these things [come] from Allah… who [created] all [the] universe"*. It was also shown to influence religious behaviours, like fasting *"there [are] five… things, every Muslim [should] do, and one of this is Ramadan."* (Z).

**Politicisation of Islam:** Participants also distinguished between Islam as a religion and the politicisation of Islam, in explaining the way they see the role of Islam in conflicts they fled. A states,

> *So what we see in Saudi Arabia, in Syria… Iran, and Egypt as Islam is actually a new creation of Islam, which [only serves] certain people [who have power in government]… but it [does not serve] everyone. It is not really…what we know about Islam… people [apply] this religion according to their own view, [where religion is used as a political game].*

Likewise, M expressed that the war in Syria is, *"between two parties… of Muslims, Sunni and Shia…Everything [bears] this Islamic name"*.

The above findings demonstrate that Islam is perceived in a positive light by participants. It is shown to influence identity, values, attitudes and behaviours. Furthermore, participants are shown to make distinctions between Islam as a religion and the way in which it is implemented and politicised.

5.5.1.2.2. World assumptions

Another theme emerging within the exploration of key beliefs was world assumptions. This included perceptions about the world, people and self.

**Perceptions of the world and people:** Participant perceptions of the world and people were considered in the premigration, migration and resettlement phase. Prominent themes emerging include social injustice, discrimination, torture within the premigration and migration phase, and social justice within the post-migration phase.

<u>Premigration</u>

In the premigration phase, all participants reported leaving their countries due to political conflict, *"[I] left [my] country because [Syria came]… under war"* (M), *"the country which is*

*my [family's] country… doesn't recognize [us] as they think that we are traitors"* (A), "*so the government [won]… after the battle [finished]… the government [caught everyone who has relatives in] Western Sudan to put in the prison… I am not guilty."* (H).

Social injustice: social injustice was a key subtheme in the premigration phase, with most participants feeling a sense of injustice in their countries. H states, "*you have no fundamental right… No justice".* Similarly, A reports*, "I thought this world is [unfair] with me because okay, my family lost their country, but there should be some kind of human system anywhere in the world just recognise this person".* M describes going on the march opposing the government which led to his arrest because, *"some [civilians] dying without any reasons. A lot of them. And [I] decided to take action".* He states, "*in Syria there is no justice*". Furthermore, he expressed a collective need for action to achieve social justice, *"the dream of freedom just cannot be [had by] one person. It needs…lot of people to work for it. So me, my cousin, my brothers, my neighbours need to have this dream to make it happen".*

Social discrimination & torture: Closely linked with social justice were subthemes of social discrimination and torture in the premigration phase. Discrimination was experienced by several participants in their countries. H states, *" Sudan… it is [an] Arab country, but we [have a mix of] black [people]. They think once you are black, you have no right to talk [to] Arabs... no justice; no equality"*. Similar sentiments were expressed by Mo, "*Sudan [is] very good, but some of the police think you come from Africa, [you're] not Sudanese…When you are walking [in the streets you hear some people calling you] bad slave".* Participants expressed experiencing feelings of alienation and disrespect due to discrimination. A reported, *"I am not part of this world, like I am sort of [an] alien"*. Mo expressed,

*In Sudan [it's] very hard because you are born in this country, you feel this is your country… I don't care about myself. I care about my family... when you have children, when you have a wife, you need… a little respect.*

Torture was another subtheme within the premigration phase, with reports illustrating the physio-psychological impact on individuals. M expressed, *"torturing [caused] pain inside. So when [I] get physical [torture], it makes [me forget] psychological [torture]"*. H reported that he was, *"in prison for five days [they asked] a lot of questions and [punished me]…after 21 days…[I thought] maybe I [would] die. I [couldn't] walk. I [couldn't] eat. I [couldn't] stand up. I [couldn't] sleep"*

Mistrust: Such experiences of social injustice and discrimination seemed to have created a sense of mistrust in their environment. H states, *"I [left] my country because I [found] myself [under attack] from those people, every time [they] come to ask about me, follow me".* Similarly, S states, *"I [couldn't] trust there. Somalia, Africa I don't trust".* A also expressed *"the hidden message was… we have no interest [in] you anymore. Either you leave this country or you stay and be like [other] foreigners".*

Participants also expressed an external locus of control in their lives in their countries and the importance of having connections and influence there. M expressed, *"back home everything is beautiful… because[of my father's connections] with the government. [My] father [has] money. [My] father [supported me] in [my]business and because of the connection [my] business…[grew]."* Similarly, H states, *"you cannot offer me [a] job because I am not [a follower of the party]".*

The above findings indicate that the political conflict has had an immense impact on participant perceptions of the world and people in the premigration phase. Specifically, there is a

perception of profound injustice, demonstrated through discrimination, and mistrust, particularly with regards to the government and its influence.

*Migration*

Most participants reported undertaking perilous journeys by car, foot and boat during the migration phase, with the ever-present possibility of death. As H expresses, "*so crowded [with] people… the boat [lost] its way, we'll die, we'll die. I [went] from [death] to [death]…my life [is] like this".*

Discrimination: Discrimination was prevalent within the migratory phase, which was reported to take the form of violence, extortion and inhumane treatment at several points of participants' journeys. During his journey through the Sahara, S states: *"they [were] waiting [at the] water place…They say everybody $50… We give some money. They say we need [more] money… They raped the women… We [tried] defending, but they [had] army cars and [guns]".*

S also describes treatment in Libya, *"you can't walk… the police, they catch you…Give money… [they arrest you]… no work, no family. And in Libya… very, very racist people."*. Similarly, Mo expressed,

> *they just take our money and they will leave you in the street. Libya is very difficult. He beat you in [the] house maybe 6 months. You never get out… He give you a little food to -- he get money from you, he [asks your] family [to] send you money to [release] you, after that [you can] go to Italy.*

Z also describes discrimination, both in Turkey, "*jengi means black… they call [you] nigger. You go nigger… [they burn cigars on] my body*" and Greece, *"they don't like especially African and Asian people… Racist [because] you are not Greek"*. On leaving Turkey Z states, *"feel so sad to leave again. I can't survive here. I have to go"* and he also describes Greece *"like in a*

*prison, but we are free… because of [racism], not happy".* Such findings highlight the difficulties faced during the migratory process, which can include discrimination, violence extortion and death.

Post-migration

Most participants were asylum seekers and had not yet gained refugee status in the UK. Therefore, this stage can perhaps be viewed as a temporary resettlement phase. Participants reported uncertainties over their status, *"I am afraid [of deportation]. I am afraid [of] detention. That's for sure."* (A). Z in discussing uncertainties over his accommodation reported*, "I plan if they say no… I am thinking maybe I will…sleep in a park"*. Despite this, during explorations of life in the UK, all participants, revealed themes of social justice, hope and optimism, with positive perceptions of people.

Social justice: Participants reported a sense of social justice and freedom; *"I get everything [I] like, I get [good] people… free education. [I got a] house, peace in life…They help me... Nobody kill me. Nobody [arrests] me"*. A also states, *"here you can feel free but [can't] work"*. Similarly, H states, "*life here is good. Everything [is] in your [hands]… a lot of freedom here.*". Mo describes life in the UK as, *"I like life here…like paradise".* Z also describes a sense of safety, *"I must say I am safe".*

Closely linked with social justice and freedom, participants also reported a sense of respect from the social system in the UK. A states, *"I am afraid [of deportation]. I am afraid [of] detention… But at least here there is some kind of respect somehow"*. Similarly, Mo states, *"people respect you. Nobody will call you slave".* M also expressed that *"one of the things which is interesting to [me] is that even… high rank officers, even if he is mistaken, they cannot be rude [to me here]".* S states about people here*, "they love you".*

Hope and optimism: Participants also described themes of hope and optimism for their lives in the UK. There was a sense of opportunities for self-development, with greater personal control and autonomy, compared to their countries, *"Here.. [you] don't get [problems]. Just yourself, if you want to be a good man, if you want to get [a job], you will get job. You want to start [studying], everything [is] open. So it's your choice now"* (Mo). Similarly, M expressed, "*back home not all the jobs [are] available… but in here nobody can control you. You work, you prove yourself, your efforts would show who you are".* A also reports, *"there is another opportunity to do something…I am not allowed to work, but that doesn't mean I cannot do some kind of voluntary things helping people".*

Social justice, freedom and its consequential values, like respect, perceived by participants highlights the greater trust that is placed on the social system. This may not necessarily relate to governmental systems but the people within the UK, compared to those within participant's countries and countries they have migrated through.

**Perceptions of self:** All participants reported changes in their self-perceptions through their experiences. Participants reported certain negative changes, which were characterised by worry, disturbed sleep and distressing memories. S, for instance, reported *"I [was] strong when I [stayed] in [ Somalia]… if you get [more and more] problems… then… I think [you] worry"*. Mo reports *"sometimes [I] still wake up from sleep… [I] remember something, but not like [before]"*. M also expressed *"now… the feelings that [I] feel inside is [worse] than what [I] used to feel during the process of [torture]".*

Despite this, most participants reported a renewed perspective of themselves and their lives due to their adversities. Mo, for instance, stated *"all suffering really [makes] me strong".* Z also stated, *"I [learnt] a lot of things... [maybe I can say I have the] experience of life".* M reported,

*[I've] changed a lot. Before [I] was like any young man. [I] wasn't worried about tomorrow… But right now [I] realized that [I need] to learn a lot…, not just dream [as] this young man [used to] dream. [I need] to dream [about] more important things, which [has] really helped not just [me], [but] many others. Even [in my] country.*

Similarly, A expressed,

*I was [the] type of character who when I get hurt… that stays with me and I keep thinking about it, how am I going to get this person [back]? …I realized that if you… would like to make [a] change, you should… leave the past behind you, and start… completely new.*

H expressed a sense of finally being able to think about self-development, *"I am looking to develop myself to be in [a] good position... I want a lot of things like all [people], all [humans] you know, more [of] life".*

The above findings demonstrate the complexity of the refugee/asylum seeker experience, where potentially pathological symptomology may sit alongside renewed perspectives of oneself, with a sense of hope, optimism and growth.

*5.5.1.3. Coping strategies*

Another important subtheme within psychological processes was coping strategies. Participants were found to use a number of coping mechanisms. Given the cognitive focus of this study, only cognitive strategies are described. Participants used a number of common cognitive strategies including, adversity as a motivator, coping using Islam, hope and striving and perceptions of psychological support.

**Adversity as a motivator:** Several participants reported using their adverse experiences to drive them to survive and strive for a better life. H states, *"never give up, because I have difficulties [in] my way… I like to overcome everything. I [see] the problem. I fight [the] problem… I*

*continue my life because I am still alive".* M expressed wanting to keep his belief in justice and freedom for his country alive through his painful memories, *"[I don't] want to cope because [I] don't want to forget the reason that [I] left the country. [I] want to keep [remembering] that reason"*

Participants also reported that the suffering of their family and community was a motivational factor. Specifically, participants seemed to demonstrate the relative gratification effect. M expressed, *"all of [my thoughts are] about... [my] country, and the people who [are living] back there… what's [happened to them]".* Furthermore, in discussing coping during his torture M reported*, "[I] saw people who [had] been tortured in there… more than [me]… And [my torture compared] to them [was] very little."*

Similarly, A stated,

> *what… really changed me [was] when I saw my family losing their dignity… I have a handicapped brother [who lost] the medication rights.. I was really terrified… I [didn't] want to see him… dying…here [is] where I [got the] power to challenge things [around] me.*

**Hope & striving:** Participants also expressed hope for their lives, which seemed to be driven by a sense of striving and self-development. H states, *"I'm going to start again here…everything is going to go right… I'm going to join [university]…also I'm waiting [for] my [papers] and my interview… I'm going to start my life seriously. Never give up".* Likewise, M expressed, *"right now [I need] to handle this time [so that] in the future [I] can learn something from here… [things are] getting bad in Syria [I] would [want] go [back and] apply what [I learnt] here."*

**Coping using Islam:** All participants reported using religion as a coping mechanism. Participants described using a number of positive strategies including prayer, recitation of holy scriptures, the use of religious historic examples and a belief in an afterlife, generally and also

specifically in the premigration, migration and post-migration phases. No negative religious coping strategies or religious struggles were reported.

Participants reported using prayer as a general coping mechanism. S expressed, *"when I see [a] problem, I say Alhamdulillah and every time I [believe] tomorrow is okay".* Similarly, Z states, *"I pray [in] my language… to God.. You can speak any language. And sometimes God [looks inside] our heart".*

Participants also cited historic religious examples as facilitating their coping, through motivational means, imbued by the Prophet Muhammed and his companions. Mo states, *our Prophet Muhammad…[he also] suffered…they [tried] to kill him…and… he [migrated]… After that he [became] strong and supported himself by a lot of dua[1]… I will [seek to follow] like [him].* Likewise, A states*, "I [read] about the history of… Prophet Muhammad…and Omar[2] and when [I isolated] myself… I [saw] how [Omar coped with] that".*

Participants also describe specific instances in their experiences where they used Islam as a coping mechanism. For example, within the premigration phase, M states, *"during [prison]… [I] started reading a lot of Quran… [I] realized [before I] was [a] careless person… But right now [I believe] more than before".* Islam as a coping mechanism was also used in the migration phase. In undertaking a journey by sea, Mo expressed placing trust in God through prayer,

> *you don't know if I cross the sea [from] Libya to Italy. Maybe I would die halfway. So we need to do Istikhara. That [means you leave anything that happens] to you to Allah… whenever [you] get [a] problem… you leave everything to Allah.*

1 Dua: an Islamic phrase meaning supplication or invocation
2 Omar ibn al-Khaṭṭāb: an important companion of the Prophet Muhammad and second caliph (ruler) following the Prophet (Khan, 2004).

Here, Mo describes 'Istikhara', the prayer of guidance, in which one asks God to facilitate the decision making process and grant contentment with the outcome. Similarly, S reports that several people turned to religion during the dangerous boat journey, *"la ilaha illallah[3], because everybody, [whatever he believes he does]."*

Islam was also used to cope in the post-migration phase. For instance, exploring how participants currently deal with distressing memories, S stated, *"I try sometimes [going to the] Masjid[4]. I read the Quran… Quran, I get relaxed".* Additionally, S describes the mosque being a part of his social support network in the UK, *"I get more friends [in the] masjid… I go masjid 5, 4 times".* Similarly, M expressed finding peace through religious coping methods, *"right now when [I am] doing all that praying, helping [people out], it does really make [me]…feel comfortable…, previously, [I] wasn't even [that comfortable] when [I] was having fun all the time."*

Participants also expressed that Islam facilitated their outlook on life following their traumas. It seemed to make salient the belief in an afterlife. Z states*, "this world is not permanent…This life is temporary. [You] don't need to be sad a lot. When I think [what this] life is, I [feel] happy".* In coming to terms with his experiences, M expressed his faith in an ongoing sense of justice beyond this world, *"there is [an] end for [my] life today and there will be another other life where there will be [judgment]".*

**Perceptions of psychological support:** Another subtheme was participant perceptions of psychological support. Most participants demonstrated limited knowledge of psychology. Z states, *"I don't have any idea to why [you would] go to [a] psychologist.. I don't know lot of things about psychologist".* This could be as Mo reports, *"in my country we don't have money to go to a*

3 An Arabic phrase meaning, 'there is no God but Allah'
4 The Arabic word for mosque

*psychology doctor".* Furthermore, Mo describes the stigmatised perception of psychological support, *"people [who] go say crazy things, get crazy… [that's what] people think in my country".* He also states, *"I believe you [can] never touch my problem.. if you get [a] problem [with] your mind you [can] never fix [it]".* Others describe using more personal and social methods of gaining support. Z states, *"I never see psychologist. That's why I am trying to [think] myself, what can I do? … I like to be busy all the time.".* Similarly, S states, *"I am a psychologist".* In dealing with distress in their countries, participants expressed that one would *"just [go to your home]"* (H). Similar sentiments were expressed by Mo, *"when you get [a] problem [stay with your family]".*

There were two participants with knowledge of psychological support. H expressed *"[psychologist] maybe [a doctor]…. You have a right to go [to] him… doesn't mean that if you go [to] the psychologist that… you are crazy... Mostly, for example, for advising".* A expressed seeking some form of psychological support in his country, this seemed to be with a person he knew*, "because maybe I know one [therapist]".*

Only one participant, M, was currently undergoing psychological therapy. He describes the lengthy process of gaining psychological process and the uncertainty involved, *"there are many different places…That's why [I] say [its] not just one doctor, many doctors… [I tell my] story and then they transfer [me] to another place… [I] don't know exactly [what's] to come"*

In terms of the therapy itself M expressed, *"nothing [has] changed [in my] mind…It's very hard. Complicated".* In exploring the importance of religious/cultural background of the therapist for M, he describes the significance of a human connection above all, "*we all are human. And culture, religion is [yours], what you want to believe… follow is up to you. The most important thing is what I want from you and what you want from me".*

## 5.6. Discussion: qualitative findings

The qualitative study aimed to further explore and explain quantitative findings. Semi-structured interviews were used, which allowed participants to share their perspective within pre-determined areas, in keeping with the essence of Counselling Psychology (Yeh & Inman, 2007). It was also used to investigate the 'quality' and 'nature' of participants experiences, beliefs, behaviours and the interactions between these (Brown, 2005, p. 485). Using Braun and Clarke's (2006) framework for thematic analysis several themes arose, which were considered in light of key psychological processes implemented in trauma processing (Brewin & Holmes, 2003). Central themes relevant to this study included trauma appraisals, beliefs and cognitive coping mechanisms. Contrary to quantitative results, qualitative findings revealed the importance of Islam in influencing trauma appraisals, world assumptions and coping strategies.

### 5.6.1. Trauma appraisals

Models and interventions of PTSD have underlined the importance of trauma appraisals in the onset and maintenance of the condition (Ehlers & Clark, 2000; Jobson, 2009). These appraisals and their consequences can aid or hinder posttraumatic adjustment and recovery (Kleim et al., 2007). Within the theme of trauma appraisals, two sub-themes were, immediate and religious trauma appraisals.

Immediate trauma appraisals reflected retrospective evaluations of participants' trauma as they experienced it during the pre-migration and migration phases. Participants described the salience of and proximity to death, a sense of not being oneself and a lack of personal control. This adds support to the body of literature demonstrating high levels of trauma exposure, like war experiences and abuse, among this population (Fazel et al., 2005; Marwa, 2016; Priebe, et al., 2016). Current findings also align with research demonstrating the fear, fatigue and grief

experienced among such samples, including high rates of physical violence and torture (Quosh et al., 2013). Findings seem to offer retrospective insight into the psychological processes occurring for this sample at the time of trauma experiences. This highlights the emotional intensity of situations and individuals' state of mind with the impending possibility of death.

Closely linked with immediate appraisals was the subtheme of religious appraisals. Participants were found to contextualise their experiences within the Islamic framework, with adversities being attributed to God's will or viewed as a test. These findings add support to research on collectivist cultures, where trauma appraisals were analysed using cultural values, including certain participants attributing experiences to pre-determination by God, fate or external causes (Engelbrecht, & Jobson, 2016). This aligns with the Islamic belief of God as, "the Creator of all things… Guardian and Disposer of all affairs" (Quran, 39: 62-63).

Participants also drew on Islamic concepts like *tawakkal* (trust or reliance on God), *rizq* (sustenance provided by God to man) and a belief in a better afterlife in evaluating their adversities (Leaman, 2006). These are encompassed within central Islamic principles. Within the Quran (65:3) it states, "he provides for him from (sources) he never could imagine… if anyone puts his trust in God, sufficient is God for him". This verse demonstrates the interconnectedness for Muslims of faith, God as the sustainer and reliance on God. This may hinge on the essence of Islam, surrendering oneself to God.

This reliance on God, faith in his sustenance, in this life or the hereafter, can perhaps explain participants acceptance of their challenging past and present experiences. This acceptance and gratitude was conveyed through expressions like *alhamdulilah*, all praise be to Allah (Huda, 2018). Traumas also appeared to strengthen participants' belief in the transient nature of this world and foster a greater sense of justice and reward in the afterlife. Research demonstrates that

trauma can be viewed as a spiritual encounter, which causes one to re-evaluate prior beliefs, outlooks and ideals (Parlotz, 2002). Within Islam, trials and tribulations form an expectant part of life, "ye shall certainly be tried and tested in your possessions and in your personal selves… But if ye persevere patiently…then that will be a determining factor in all affairs" (Quran, 3:186). It is also stated "God is with" and "glad tidings" are given to those who patiently persevere (Quran 2:153). The association between patience, being in the presence of God, the promise of greater blessings and future rewards perhaps creates a sense of acceptance and gratitude of participants' difficulties. Therefore, participants' perspectives of their trauma seem in line with the Islamic view towards adversities, which is to bring a sense of self-development and purification. Such findings support DeAngelais and Ellison's (2017) study, where those who believed that God controlled their lives displayed more positive trauma appraisals. Current findings seem to demonstrate positive religious trauma appraisals encompassed in concepts like *tawakkal, rizq,* an on-going sense of justice and through expression like *alhamdulilah.*

These findings provide support for TMT (Greenberg et al., 1986), where cultural worldviews, like religion, are said to provide meaning, purpose and manage the terror created by mortality awareness. Therefore, belief in God's will and *tawakkal* may have facilitated participants in dealing with their mortality awareness. While TMT may explain participants' use of religion in trauma appraisals in its aftermath (i.e. distal defences; Routledge, Arndt & Goldenberg, 2004), participants do not seem to demonstrate proximal defences, appearing immediately after mortality awareness and involving the denial of death. Instead, they display an acceptance of death. This is perhaps in line with the Islamic notion of the continued existence from life into death and the hereafter. An alternative explanation could be weakened worldviews in premigration, where previous adverse experiences may increase morality reminders making it

difficult to deny death (Hayes, Schimel, Faucher & Williams, 2008; Schimel, Hayes, Williams & Jahrig, 2007). It is acknowledged, however, that the study did not directly examine proximal defences.

Participants also reflected on Prophet Muhammed's experiences of adversities and migration. The Prophet is reported as saying, "the greatest reward comes with the greatest trial. When Allah loves a people He tests them" (Ibn Majah, 536:106). A revered figure's endurance of similar hardship, and his resulting words of wisdom, seemed to provide participants with meaning for their experiences. It perhaps contextualised their experiences as part of a greater plan.

Islam seems to play a significant role in the meaning-making process of trauma for this sample. Trauma appraisals seem to be underlined by the fundamental belief in God's will, which were linked to concepts like reliance on God and sustenance provided by Him. Furthermore, adversities were viewed within the Islamic framework, with difficulties seen to provide opportunities for self-development, purification and the promise of blessings and a better afterlife. These findings contrast with quantitative results, where religious coping and identification did not explain substantial variance in trauma appraisals.

### 5.6.2. Beliefs

Another key theme found was beliefs. Relevant to this study were Islam and world assumptions. World-view based models of trauma (Janoff-Bulman, 1992), Ehlers and Clark's (2000) model and empirical research on PTSD (Dunmore, Clark, & Ehlers, 2001) have highlighted the significance of beliefs and assumptions for individual trauma reactions.

#### *5.6.2.1. Islam*

Within the theme of Islam, sub-themes included perceptions of Islam, Islam and identity and the politicisation of Islam. Islam, as a religion, was viewed in a positive light. Participants described

it as “perfect”, “peaceful”, stable, a significant part of their lives and as providing a framework for life. There also seemed to be a sense that the righteous application of Islam resulted in a worthy life. Therefore, for participants through Islam “the programme of my existence is thus completely mapped out… collective attitudes and individual behaviour are determined” (Boudbia, 1998, p. 9).

Participants distinguished between Islam as a religion and the use of Islam as a political tool to justify the conflicts from which they fled (politicisation of Islam). The Middle-East is currently inundated with intra-Muslim conflicts, from the civil wars within Syria, Iraq and Libya and domestic tensions within Lebanon and Bahrain to the strife between Iran, Yemen and Saudi Arabia, which seem to be underlined by the Sunni-Shia rivalry (Akyol, 2016). Of relevance, is the impact of such perceptions of politicisation on Muslims. This presents a challenge, as the Muslim identity is now synonymous with threat and terrorism, which has further influenced public perceptions of refugees (Bayrakli & Hafez, 2016). The ‘Muslim’ and ‘Islam’ labels are, therefore, argued to be politicised both from the country from which refugees flee but also within host nations (Fiddian-Qasmiyeh & Qasmiyeh, 2010). Through the distinction made between Islam as a religion and as a political tool, participants demonstrated that their perception of the religion remains positive and unwavering, despite their experiences in the so-called name of Islam.

The above distinction of Islam seems to have implications for the Muslim identity. Islam was shown to positively influence participants’ values, attitudes and behaviours. Religion seemed to provide a moral compass for participants, for instance, influencing considerations of revenge. It was also shown to impact values like patience, behaviours like helping others and religious behaviours like fasting and praying. The concept of patience is shown to be integral within Islam

as a value, attitude and behaviour and is linked with faith in God's will (Quran, 3:186). Furthermore, Prophetic teachings impart important values and duties (Bukhari, Ahmad & Ali, 1956). Thus, Islam seemed to impact participants' personal and collective identities, in line with Fiddian-Qasmiyeh and Qasmiyeh's study (2010) on religious identification among Muslim refugees/asylum-seekers. Such findings also support research demonstrating that religious faith is a fundamental part of cultural identity (Betancourt et al., 2015) and that religion has a significant impact on attitudes (Buber-Ennser et al., 2016). Contrary to previous research (Colic-Peisker, 2009; Warfa et al., 2012) and the politicisation of the 'Muslim' and 'Islam' labels (Fiddian-Qasmiyeh & Qasmiyeh, 2010), there were no reports of discrimination specifically related to the Muslim identity.

The impact of Islam on identity, however, was explored broadly. Specific aspects of identity, like visibility factors or the impact of current political perspectives on the Muslim identity, were not explored. This forms a limitation of this study. It, however, offers directions for future research within these areas. Nevertheless, the influence of Islam on participants' identities is shown to run deep, impacting values, attitudes and behaviours towards the self, world and other. Religion is shown to provide a moral and ethical guidance. This underscores the importance of faith for participants, despite adversities violating basic human rights. Such findings contrast with quantitative findings, where religious coping and identification did not explain substantial variance in trauma symptoms, appraisals and world assumptions.

*5.6.2.2. World assumptions*

Another theme emerging within explorations of beliefs was world assumptions, this included perceptions about the world, people and the self. This is in line with worldview-based models of trauma (Janoff-Bulman, 1992; Pyszczynski & Kesebir, 2011; Solomon et al., 1991). Participant

perceptions of the world and people were considered in the premigration, migration and post-migration phases, in attempting to capture the entirety of the refugee/ asylum seeker experience (Khawaja et al., 2008; Martin, 1994).

In the premigration phase, all participants reported fleeing their countries due to political conflicts. Social injustice, discrimination and torture were key subthemes. Participants reported discrimination due to race (i.e. their black skin colour), ethnicity (being African) or socio-economic status. Consequently, most participants reported feelings of injustice and unfairness in their countries, with expressions of alienation, loss of personal control, autonomy, dignity and respect. These are significant as previous research has implicated isolation and loss of control/autonomy appraisals as critical to PTSD aetiology and maintenance (Brewin & Holmes, 2003; Ehlers et al., 2000).

Half the sample reported experiences of imprisonment and torture within this phase. Accounts illustrated the traumatic physio-psychological impact on individuals, which suggests cognitive-affective reactions of fear and helplessness. Certain participants showed the researcher physical scars left from these incidents. Research has shown that amongst those experiencing violent crimes, severe feelings of fear and helplessness were shown to predict PTSD (Brewin et al., 2000). Such experiences, fuelled by the political situation, seemed to produce feelings of mistrust in their environment.

These findings support existing research highlighting the importance of pre-migration factors on refugee/asylum seeker mental health (Castaned, et al., 2017; Farhat et al., 2018; Porter & Haslam, 2005). This study also supports research demonstrating the varying amounts of potentially traumatic experiences (PTEs) like discrimination, imprisonment, witnessing or experiencing violence and torture among populations exposed to war and conflict (Castaned et

al., 2017). Current findings also support Groen et al.'s (2017) qualitative study, emphasising the significance of ethno-religious issues within the pre-migration phase as being PTEs for participants, by creating fear, despite their cultural identification as Muslims. For current participants, the impact of ethno-religious issues and consequent experiences are perhaps explained through their perception of the politicisation of Islam.

Most refugee studies have focused on the epidemiology of mental health conditions and post-migration experiences (Bogic et al., 2015; Fazel et al., 2005). Current findings seem to provide an understanding into pre-migratory conditions, their psychological impact on participants and why participants left their countries. It highlights world assumptions within participants' pre-migratory world, which seem encompassed by a sense of injustice, unfairness, isolation and lack of personal control and mistrust. Furthermore, these findings also provide insight into the mental state of individuals during distressing experiences, like their imprisonment and accompanying torture, through their retrospective reflections.

During migration, most participants reported undertaking perilous journeys, by car, foot and boat, with the pervasive possibility of death. Discrimination was the most prevalent subtheme, with participants reporting experiences of primary and secondary violence, extortion and inhumane treatment at several points of their journey. Research on violence experienced during the journeys of Syrian refugees found that 24.8–57.5% of participants experienced violence en-route to Greece by smugglers, policemen and guards (Farhat et al., 2018). Such findings are important as most studies on discrimination within refugee populations have focused on the post-migration phase (Portes & Rumbaut, 2001; Werkuyten & Nekuee, 1999). Current findings provide insight into the challenges encountered during migration and indicates world assumptions of mistrust in participants' environments.

The post-migration phase contrasts with the pre-migration and migration phases. While most participants were asylum seekers and expressed uncertainty over their immigration status and in one case accommodation, they reported optimistic perspectives of their lives in the UK, with themes of social justice, hope and positive perceptions of people. Participants reported a sense of social justice, freedom and respect from the social system in the UK. They also expressed hope and optimism for their lives, a sense of opportunities for self-development contingent on oneself, greater personal control and autonomy compared to their countries.

According to Ehlers and Clark's (2000) model, the trauma memory stays an unincorporated, uncontextualized situation-specific depiction that becomes linked to the working self and its goals, which creates PTSD symptoms. The trauma can, however, be activated in the future through the initiation of goals linked to the working self. The ability for participants to have goals linked to the working self within the postmigration phase, has perhaps facilitated the contextualisation of their trauma experiences. This is perhaps depicted through participants' capacity to present a coherent narrative of their trauma experiences. It is, however, difficult to draw conclusions about the contextualisation of participants memories, given that interferences and misrepresentations in their autobiographical memories following trauma exposure was not tested.

Current findings support research demonstrating an overall sense of satisfaction among refugees despite post-migratory challenges (Fozdar & Torezani, 2008; Ryff et al., 2003). Findings on perceptions of fairness within the UK are in line with Fozdar and Torezani's (2008) study, which showed that post-migratory challenges did not seem to impact participants' perceptions of Australia as a fair country. Participants seemed to display the relative gratification effect (Pettigrew, 2002), by drawing comparisons with worse experiences, i.e. life in their

country. Such optimism could also be the result of eudemonic well-being, where difficult experiences may create a more profound sense of meaning and purpose for life (Ryff et al., 2003).

This eudemonic well-being was shown to impact participants' self-perceptions. All participants reported changes in their self-perceptions due to their experiences. These included certain negative changes, like worry, disturbed sleep and distressing memories. This could be indicative of post-trauma symptoms (APA, 2013), which are typical for survivors in the aftermath of trauma experiences (Rothbaum, et al., 1992). Alongside such symptoms, participants reported renewed perspectives of themselves and their lives due to their adversities, with a greater sense of strength and purpose in life. This seems indicative of post-traumatic growth (PTG), which research demonstrates results in a greater propensity for personal vigour, gratitude for life, life outcomes and spirituality (Dekel et al., 2012). Current findings also support the positivistic school of thought (Seligman & Csikszentmihalyi, 2000) and past salutogenic models (Antonovsky, 1979), where trauma survivors are thought to gain certain psychological advantages.

These findings also add support to the large body of PTG evidence (Calhoun & Tedeschi, 1989; Shaw et al., 2005) and to specific PTG research among refugees. For instance, Teodorescu et al.'s (2012) study, which reported an extent of PTG among all psychiatric refugee participants in Norway. Similarly, Werkuyten and Nekuee's (1999) study on Iranian refugees in the Netherlands found that a sense of self-mastery predicted positive emotions and life satisfaction. Research on PTG has further demonstrated that the determining factor in the degree of growth is the strife following the trauma and the way in which one deals with repercussions (Tedeschi & Calhoun, 1995). Those experiencing trauma attempt to resolve their experiences through

meaning-making processes, like religion, which may be a contributory factor towards PTG (Prati & Pietrantoni, 2009). Indeed, participants within the study reported turning to religion as coping mechanism in dealing with distressing, which appeared to strengthen their faith (section 2.5.3).

The qualitative findings on self-perception do not support quantitative results, which demonstrated that negative perception of self significantly positively predicted trauma symptoms and self-blame significantly negatively predicted trauma symptoms. Within qualitative findings, however, participants reported experiences of trauma-related symptoms alongside more positive changes in their self-perception. There did not seem to be evidence of negative self-perception or self-blame.

What seems noteworthy about these findings is that participants' world assumptions do not remain fixed but seem context-dependent. This is somewhat contrary to Ehlers and Clark's (2000) model, where an individual's previous beliefs and experiences are said to considerably impact their post-trauma appraisals and cognitive coping. Prior trauma exposure and cognitive-affective reactions like helplessness or vulnerability are thought to raise susceptibility for the posttraumatic self being evaluated as vulnerable, futile and frail (Dunmore et al., 2001). Furthermore, perceptions of loss of control and autonomy, as reported within the premigration phase, are thought to bring about mental defeat, which is shown to increase the risk of the posttraumatic self being appraised as fragile and inadequate, which maintains PTSD (Mesquita & Walker, 2003). Mental defeat was not observed within this sample. While participants expressed mistrust and injustice within the pre-migration and migration phases, their views within the post-migratory phase seems more optimistic with reports of social justice and greater trust. It is acknowledged, however, that pre-trauma beliefs were not fully explored in this study.

There appears to be a significant prior belief overarching these world assumptions. It is argued that this is Islam for these participants. In accordance with the Meaning-Making model (Park, 2005), Islam could be viewed as the global meaning-making process, providing meaning at a worldview level, while the world assumptions described form situational meanings, more daily meaning-making processes. This model seems to provide one explanation of how Islam may provide a meaning-making framework for individuals, especially in dealing with their trauma experiences. An Islamic worldview encompasses God as the sustainer of the universe, the determiner of destinies, and humans as good but with certain frailties and in need of divine guidance (Abdullah & Nadvi, 2011). Therefore, the use of Islam as a global meaning-making framework explains how participants may use religion to contextualise their trauma experiences, as demonstrated through participants' religious trauma appraisals. Belief in God's will may perhaps lessen the importance of personal control over one's destiny for Muslim trauma survivors (Mesquita & Walker, 2003). This may function as a protective factor against mental defeat and feelings of helplessness and vulnerability. This supports TMT (Greenberg et al., 1986), where cultural worldviews, like religion, are said to mitigate the terror caused by mortality salience. Therefore, the context-dependent world assumptions, seem to be encompassed within a larger Islamic framework, influencing participants' overall values, attitudes and behaviours in all migratory phases.

These qualitative findings seem to align somewhat with exploratory quantitative analyses on trauma symptoms and world assumptions. The greater CE, CPP and TGP perceived, the fewer trauma symptoms were reported, with trustworthiness found to be the only significant predictor in the model. Likewise, within qualitative findings, participants seemed to report greater trustworthiness, CPP and CE within the post-migration phase. This appears to positively impact

their functioning, with expressions of social justice, freedom, hope, optimism, sense of striving and self-development. Participants also expressed feeling safe in the UK, contrary to quantitative findings, where no significant correlation was found between SV and trauma symptoms.

The focus of the qualitative study, however, was not trauma symptoms and functioning. Therefore, the specific impact of world assumptions on trauma symptoms was not directly explored. Furthermore, it is acknowledged that to fully understand the impact of world assumptions on trauma, participants' pre-trauma assumptions need to be examined to draw empirical comparisons between pre- and post-trauma world assumptions. This is challenging from a research perspective, not only given the cross-cultural and longitudinal nature of such a study but also given that many countries remain war-torn.

#### 5.6.3. Cognitive coping

The cognitive coping of participants was also explored, which revealed sub-themes like coping using Islam, adversity as a motivator, hope and striving, as well as perceptions of psychological support.

Religion was shown to be a significant coping mechanism for all participants. Several positive religious coping strategies were described throughout the refugee/asylum seeker experience, including prayer, Quranic recitation, the use of religious historic examples and a belief in an afterlife. These findings add support to the literature on Muslim refugee samples and religious coping, demonstrating religion to be a positive coping mechanism, through spiritual practices like prayer, placing trust/fate in God and reading Quran (Ahmed et al., 2017; Byrskog et al., 2014; Simmelink et al., 2013; Teunissen et al., 2004; Thomas, et al., 2011; Valtonen, 1998; Yaser et al., 2016). No negative religious coping was reported.

Qualitative findings add support to Pargament's (1997) Religious Coping Theory, where religion is said to provide believers with meaning and coping strategies during times of distress. These findings add support to the body of literature demonstrating that prayer is a significant coping strategy for individuals, during increased emotional distress, especially where other coping resources are unavailable or inadequate (Koenig et al., 1988; Ellison & Taylor, 1996; Pargament, 1997). These findings also seem to provide support for TMT (Solomon et al., 1991), where cultural worldviews, like religion, are said to play a defensive role in protecting against the fear of mortality through beliefs like those of an afterlife. Additionally, current findings support the Meaning-Making model (Park, 2005), where religion is seen as one method of offering global and situational meaning. Here, Islam as a global meaning-making framework is shown to impact coping attitudes and behaviours.

Current findings are also in line with Ehlers & Clark's (2000) model, which proposes that coping strategies used in preserving an individual's safety are linked to the person's evaluation of the trauma and their overall beliefs about coping. Indeed, research among collectivist cultures demonstrates that when trauma appraisals were linked to God's will, fate or external causes, this was associated with religious coping methods (Engelbrecht, & Jobson, 2016). Current findings suggest that the Islamic belief not only affects trauma appraisals but also has an impact on coping behaviours, all of which seem hinged on the fundamental belief of divine will.

Current findings, however, do not support Slewa-Younan et al.'s (2017) study, which found that in attributing causal factors for PTSD, certain Afghan and Iraqi refugees rated punishment from God and problems related to destiny as being likely or very likely. Current findings also do not seem to support Vujcich's (2007) study, where expressions of religiosity upon resettlement were dependent on pre-migration religiosity and post-migration interaction with other Muslims.

Current findings seem to suggest that pre-migration religiosity does not play a large role in expressions of faith. All participants report utilising religious coping as an important tool in the post-migration phase, regardless of their pre-migration religious affiliation, with most participants reporting a strengthening of faith post-trauma. It is, however, acknowledged that pre-migration religious affiliation was not examined in depth within this study, as this went beyond the scope of the study.

Why might participants use Islam to cope? Participants described using prayer and recitation during distressing periods of their refugee/asylum seeker experience, like imprisonment in the pre-migration phase, undertaking sea journeys and in dealing with distressing memories post-migration. Prayer within Islam, is based on the foundational notion of surrendering to God. It could be viewed as a method of materialising concepts like *tawakkal* (trust in God) and *rizq* (sustenance from God). Prayer serves not only as a method of coping but also healing, "unquestionably, in the remembrance of God do hearts find satisfaction" (Quran, 13:28). Neuroscience data on intense Islamic prayer reveals that the experience of surrender within prayer practices was associated with decreased activity in frontal and parietal brain region, associated with emotional control, a sense of spacelessness and connectedness to God respectively (Newberg et al., 2015). The latter study provides an explanation for the positive psycho-physiological impact of prayer for participants within the current study and Muslims generally.

Participants also seemed to draw on religious historical figures, specifically the Prophet Muhammad and his companions, as a motivational means of coping. They drew parallels with the Prophet and his companions' difficulties, and drew on their coping methods. Within the Quran it said about the Prophet, "the Apostle of God is a beautiful pattern of (conduct)" (Quran,

33:21). This demonstrates that the Prophet serves not only as a vessel for the divine message but also plays a significant function as role model, imparting values and behaviour, highlighting social injustices and encouraging social activism (Noegel & Wheeler, 2002). Such religious exemplars may perhaps offer participants both a sense of comfort, perspective and a motivation for striving in life and religion.

Belief in the afterlife was another religious coping mechanism utilised by participants. They expressed that Islam facilitated their outlook on life following their trauma experiences, by making salient the belief in an afterlife. Participants reported on the temporariness of this life, and judgment and justice in the hereafter. Such findings add support to TMT (Greenberg et al., 1986), highlighting the protective role of religious beliefs, like the afterlife, in the face of one's mortality. Current findings also support research indicating the use Islam to make sense of war atrocities and provide a sense of justice (i.e. if not in this life, in the next) (Vujcich, 2007). The afterlife addresses the association between human actions and divine judgment, and acknowledges consequences for individual action in this life (Esposito, 1999). This divine judgment and justice may provide participants with a source of comfort, especially given the many social and personal injustices experienced (Krause, 2011). Consequently, the temporal nature of this life and all its challenges may be perceived as less alarming to a believer's core identity (Idler, 1995). The unique meanings associated with distress and the promise of impending, eternal spiritual rewards may make it easier to endure (Foley, 1988; Pargament, 1997).

While the applicability of TMT for this sample is acknowledged, given Islamic beliefs about death, it is questioned whether for Muslims it is the terror of their mortality or the uncertainty of the next chapter that turns individuals to religion during mortality salience. This is an area for

future research, which may provide a greater understanding of why belief in an afterlife serves as a coping strategy for trauma.

Participants also reported using their adversities as motivation, driving them to survive and strive for a better life. These findings support the literature highlighting the resilience of refugees and the potential for PTG in the face of adversity (Teodorescu et al., 2012; Werkuyten, & Nekuee, 1999). Participants reported that the suffering of their family and community was also a motivational factor in dealing with their distress. This emphasises the importance of the collectivist identity for these participants, in line with research showing that group identity played a protective role with psychological and wellbeing benefits (Alemi & Stempel, 2018; Çelebi, Verkuyten & Bagci, 2017). These findings also support Englebrecht and Jobson's (2016) study, where trauma consequences were perceived in relation to the one's group, with the self as a secondary characteristic. Such collectivist underpinning may derive from the Islamic concept of ummah, the community of believers, which underlies the Muslim social identity (Armstrong, 2007).

Another key cognitive coping strategy was hope and optimism. Participants expressed hope for their lives, driven by a sense of striving and self-development. They expressed a positive outlook for their future, wanting to live their lives and establish themselves. Hope seemed to offer an optimistic outlook for present and future stressful contexts (Snyder et al., 1991). Hope could, therefore, be seen as a form of positive reappraisal coping "the adaptive process through which stressful events are re-construed as benign, beneficial, and/or meaningful" (Garland et al. 2011, p. 60). The perception that one has the ability to achieve a positive future, however, realistic, can be a significant motivator for war refugees to endeavour to conquer the traumatic consequences of war (Ai et al., 2002). Research on Kosovan refugees has demonstrated that hope

and cognitive coping strategies were associated with PTG, when controlled for war trauma and baseline symptoms (Ai, Tice, Whitsett, Ishisaka, & Chim, 2007). Optimism was found to be positively associated with positive religious coping, which was consequently correlated with greater religiosity. While optimism and PTG were not directly examined, current qualitative findings seem to support the association between optimism, positive religious coping and PTG.

Previous research on refugees has also shown that religious beliefs like placing trust in God's plans, were found to be associated with endurance, which provided a source of acceptance and hope (Anjum et al., 2012; Byrskog, et al., 2014). Within the current study, trauma appraisals linked to God's will may have underlined participants' coping strategies, illustrating a sense of acceptance, hope, optimism and endurance. This is in line with research indicating that religion was found to provide participants with a source of strength and support, emotional/therapeutic support, hope, familiarity and continuity (Papadopoulos et al., 2004). Therefore, religious beliefs seem to serve as a cultural health assets (Lightfoot et al., 2016).

Hope forms an integral belief within Islam and is closely linked with God's mercy, *rahma*. This is illustrated in the Quran where Jacob states, "never give up hope in God's soothing mercy" (Quran, 12:87). This demonstrates the interconnectedness between the concept of faith in God, hope and His mercies. The notion of sustenance is believed to be based on God's mercy and compassion (Engineer, 2001). Consequently, the hope expressed within current findings may be associated with previously highlighted themes like God's will, reliance on God (*tawakkal*) and sustenance from God (*rizq).* Therefore, the hope and striving demonstrated here may originate from a belief in God's role as the provider.

Another topic explored within the theme of cognitive coping were perceptions of psychological support. Most participants seemed to have limited knowledge of psychology and

what it can offer. One participant expressed affordability as barrier for seeking support within his country. Participants reported on the stigma attached to mental health within their community, with seeking help being linked to perceptions of madness. This supports findings on cultural explanatory models of mental health and stigma among refugees (Carroll, 2004; Laban et al., 2008). Participants also reported using personal and social methods of gaining support, like dealing with issues themselves and utilising social support, like family and friends. This is line with previous research among refugees, which demonstrates the importance of social support as a coping mechanism for trauma (Alemi et al., 2014; Carroll, 2004; Siriwardhana et al., 2014).

There were two participants with knowledge of psychological support, one who had not sought treatment and another who reported undergoing treatment only because it was with a therapist he knew. There was only one participant who was undergoing psychological therapy. He describes the process of seeking treatment as lengthy and unclear. He expressed the therapeutic process itself as 'hard' and 'complicated'. Interestingly, in exploring the importance of the religious/cultural background of the therapist, the participant expressed the significance of a human connection above all.

These findings support existing research on barriers around refugee mental health. Bartolomei et al. (2016), in a study among mental health and primary-care workers of refugees in Switzerland, reported a significant barrier was limited information about mental health and psychiatry. A systematic review of qualitative studies exploring access to mental healthcare among professionals working with refugees/asylum seekers in high-income countries found encounter-level (e.g. trust, communication, culture) and service-level challenges (training, connecting with other services, resources) (Robertshaw, Dhesi, & Jones, 2017). Similarly, a study exploring barriers to accessing mental health services among ethnic minorities in the UK

distinguished between personal, environmental (e.g. difficulty recognising mental health issues, stigma) and service-level (long assessment waiting times, poor communication between client and healthcare provider) challenges (Memon, 2016). Current findings appears to highlight the importance of issues, at an individual level, like trust and limited psychological understanding and at a systemic level, like cultural stigma, manoeuvring a complex healthcare network and poor communication between provider and service user. These issues may explain the difficulties experienced in participant recruitment and may have impacted responses within the study, especially within the quantitative phase, with its focus on mental health. It is acknowledged that further, more extensive research is needed to gain a fuller picture of service perceptions among this population.

### 5.6.4. Limitations of the qualitative study

There are certain limitations that need to be acknowledged with regards to the qualitative phase. Firstly, the language barrier between participants and the researcher. English was not the primary language for all participants. Five of the six participants chose to converse in English during interviews. Therefore, certain richness and depth of meaning may have been lost. It has been acknowledged that undertaking conversations in a second language can limit the insight process, with the process becoming intellectually rather than emotionally oriented, with a focus on how things are being said (Poinot, 2018). Whilst conversing in another language may have resulted in a loss of some meaning, the interview process allowed for techniques like seeking clarification (for both the interviewer and interviewee) and interpretations of body-language to gain emotional insight (Cohen, Manion & Morison, 2007). It also offered a chance for interviewees to review or add to anything expressed. Furthermore, in utilising an interpreter, this loss of meaning was mitigated through techniques like meeting with the interpreter beforehand to outline the

research and approach, clarifying key words, pacing communications and checking-in with what had been said by the interpreter and participant (Razban, 2003).

Secondly, the recognition of the collision of transferential processes has implications for both what is being said and how it is interpreted from both a participant's and researcher's perspective. From a participant perspective, this includes their experiences and how these have come to impact their expressions. For instance, the potential for response bias is acknowledged, given several potentially influential contextual factors. Hammersley and Gomm (2008) state,

> what people say in an interview will indeed be shaped, to some degree, by the questions they are asked; the conventions about what can be spoken about...by what they think the interviewer wants; by what they believe he/she would approve or disapprove of. (p. 100)

Potentially influencing factors include the researcher being visibly Muslim (wearing a headscarf), female, a trainee Psychologist and perceived as a British citizen. Such factors highlight issues around power, social position and gender to name a few (Holstein, 1990). This raises questions about the influence of these characteristics on participant responses, e.g. their positive views on Islam and life in the UK.

Another interviewee issue concerns the reality of the material being reported. It is acknowledged that participants have only provided information that they wanted to disclose about their experiences. Their perceptions are subjective and may change with time and context. Thus, it is recognised that what is expressed is the truth that participants were willing to reveal at that particular moment in time.

It has also been argued that "interviews alone are an insufficient form of data to study social life" (Walford, 2007, p. 147), with the potential for both the interviewer and interviewee to have deficiencies in memory and knowledge (Potter & Hepburn, 2005). It is acknowledged that

interviews may not provide a holistic, transparent understanding of lived experience. Perhaps an ethnographic approach may have been useful and more appropriate to study the cultural phenomena of religious coping, identification and their consequences on trauma experiences, with its emersion in the participant's world (Reeves, Kuper & Hodges, 2008). Whilst the researcher did take time to build relationships and develop trust within the refugee centres, it is acknowledged that this was not a naturalistic setting. The formal nature of refugee centres, where individuals come for immigration advice and survival assistance, may have been a further factor impacting what participants reported. The researcher reiterated anonymity and confidentiality of responses and the completely academic nature of this study. It is possible, however, that participants felt that their responses had an impact on personal contextual issues, like immigration, which may influenced their answers.

From a researcher's perspective, the importance of acknowledging one's own values and biases were highlighted, especially with research bearing personal resonance from a religious and familial perspective (Chapter 7). The researcher attempted to mitigate both researcher and response biases through reflexivity and the use of tools like Clean Language. This aimed to maintain neutrality, by being information-led, utilising information provided by participants (Lawley & Tompkins, 2004). Furthermore, the researcher's therapeutic training facilitated this process, in being grounded in humanistic and systemic foundations, where neutrality and curiosity are emphasised (Brown, 2010).

Finally, the qualitative study to a large extent and the quantitative study to a lesser extent, demonstrate a gender bias, with mostly male participants, which limits the female perspective. This was due to difficulties in recruiting female participants, despite the researcher's attempts. Females approached seemed reluctant to share their experiences, which may be due to the more

severe nature of their trauma experiences. Indeed, being female is highlighted as a risk factor for poor mental health outcomes (Bogic, Njoku, & Priebe, 2015; Porter & Haslam, 2005) and sexual and gender-based violence (Keygnaert, et al., 2012). This emphasises the importance of gaining female perspectives, which forms an area for future research.

# 6. General discussion

This mixed-methods study investigated the role of religious coping and identification on the trauma appraisals and world assumptions of Muslim refugees and asylum seekers. Previous research has demonstrated a scarcity of knowledge and understanding on the maintenance and treatments of PTSD among non-Western populations and specifically refugees/asylum seekers. Cognitive mechanisms like trauma appraisals and coping, and beliefs like world assumptions have been implicated in the onset and maintenance of PTSD (Ehlers & Clarke, 2000). Moreover, culture is found to influence cognitive appraisals and consequentially impact PTSD onset and maintenance (Bernardi et al., 2018). Despite the importance of religion demonstrated by previous research on Muslim trauma survivors and refugees/asylum seekers specifically, there remains a dearth of knowledge on the impact of Islam on the world assumptions and trauma appraisals of this population.

Furthermore, most studies examining religious coping among Muslims have utilised generic measures like RCope (Pargament et al., 1998). This study used a measure specifically designed for Muslims, the PMIR. Additionally, research on world assumptions has typically utilised the WAS (Janoff-Bulman, 1989), which has been criticised for its psychometric properties (Kaler et al., 2008). Therefore, this study used the WAQ measure of world assumptions with good psychometric properties (Kaler, 2009). Through a mixed-methods approach, this study aimed to address certain gaps in refugee/asylum seeker and religion research. The study also sought to examine general and more specific notions impacting this sample and to capture the refugee/asylum seeker experience in its entirety from the pre-migration, migration to post-migration phases.

This section attempts to explain the discrepancy between quantitative and qualitative findings, in light of existing research findings. Strengths and limitations are also considered before implications are outlined and a conclusion is offered.

## 6.1. Explaining the discrepancy between quantitative and qualitative findings

The qualitative findings demonstrate a complex relationship between religion and trauma, its appraisals and world assumption. It highlights the importance of Islam in trauma experiences and consequent responses. This contrasts with quantitative findings, where religious coping and identification did not explain substantial variance in trauma symptoms, appraisals and world assumptions. There may be several explanations for the discrepancy between these findings.

Quantitative findings provide the ability to test hypotheses and are less susceptible to theoretical and researcher biases than qualitative methods (Brink, 1995). There are, however, three main criticisms for utilising quantitative methods to study religion (Storm, 2012). Firstly, religion is too complex to be classified and measured. Secondly, quantitative approaches are too simplistic and empiricist. Thirdly, religiosity is context-dependent and vulnerable to measurement error to be effectively quantified. Given the complexity and subjectivity of religion, survey research on religion appears to be especially susceptible to context, wording and expectation (Storm, 2012). This may be especially pertinent for a cross-cultural sample with varying education levels, which may impact participants' ability to fully comprehend survey questions.

Furthermore, this research investigated two personal and sensitive topics, mental health and religion, within an Middle-Eastern/African sample. Research demonstrates that mental health generates both self and social stigmatisation within this population (Sewilam et al., 2015), which is another factor that may have impacted responses within quantitative data. The use of a

quantitative method to investigate such nuanced topics, within a cross-cultural sample seems to further complicate responses. “Language is meaningless if deprived of its cultural/emotional/familial context” (Poinot, 2018, p. 48). This method seems to overlook such contextual factors, which form an important part of one’s meaning-making process.

In contrast, the qualitative approach seems allow for the capturing of complex, contextualised and nuanced data, in exploring a “fuzzy concept” like religion (Spilka, 2002, p. 43). Indeed, Lacan viewed language as a tool that translates our unconscious to decipher our subjective truth (Conolly, 2002). The use of qualitative methods, like semi-structured interviews, adopting a narrative approach is perhaps especially pertinent for this sample, deriving from communities with historically narrative traditions (Kilito, 2014; Lightfoot et al., 2016). Additionally, the Clean Language approach used within interviews, with a focus on utilising the participant’s language and metaphors, seems to foster this narrative tradition. This narrative approach also allowed for clarification when participants did not understand questions and expansion of their answers to further elucidate responses. This was especially important given the language barriers existing between participants and the researcher. It allowed participants to provide their meaning of experiences rather than drawing on pre-determined Eurocentric categories as within the quantitative phase. This may have facilitated the more complex findings within the qualitative phase.

Flick (1992) states that mixed-methods should be utilised not as an approach for validation but as a means of “gaining access to different versions of the phenomenon that is studied” (Flick 1992, p. 194), while being aware that the methods used are appropriate for the topic under study. Therefore, one question raised here is whether quantitative methods are best suited to study such nuanced subjects like trauma appraisals, world assumptions, religious coping and identification

within this sample. This is especially pertinent given the culturally subject nature of illness, healthcare and religious beliefs. Research demonstrates that culture can strongly impact every element of illness and recovery, including interpretations of and reactions to symptoms, explanations of illness, help-seeking, coping responses, treatment styles, ways of expression and communication (Helman, 2007). Such findings are especially important in highlighting a further developmental area, ensuring the cross-cultural validation of measures like the PTCI and WAQ for the Muslim refugee/asylum seeker population, which forms a limitation of this research.

## 6.2. Strengths and implications

Whilst acknowledging the study's limitations, certain strengths need to be highlighted. The present study has attempted to investigate a hard-to-reach population, within the context of an ongoing refugee crisis. A mixed-methods approach was used to gain improved insight into research questions and complex phenomena in ways that one method may not provide (Cresswell & Planto Clark, 2007). This allowed for the expression of objective and subjective perspectives. The qualitative findings seem to illustrate an intricate picture of the relationship between religious coping, identification and trauma and world assumptions, despite religious coping and identification not explaining substantial variance in these variables. This suggests an area for further research, especially given the limited sample size within the quantitative study.

The study has tried to explore sensitive and personal issues. This includes mental health among refugees/asylum seekers and religion within academic and therapeutic fields. Whilst the study of religion is growing, literature on Islam remains scarce, especially with regards to the impact of Islam on mental health. Furthermore, research indicates that clinicians are uncertain about how to integrate religious-spiritual concepts into practice (Veiten et al., 2003). This study attempted to address this need. This is especially important given the growing number of

immigrants coming into the UK, many from pre-dominantly Muslim regions. This study provides specific insight into the role of Islam in trauma experiences for this sample, with qualitative findings demonstrating how Islam is used to contextualise trauma appraisals (e.g. God's will, *tawakkal*, *rizq*), provide coping mechanisms (e.g. prayers, reading Quran) and influences values, attitudes and behaviours. This links Religious Coping Theory (Pargament, 1997) with Ehlers and Clark's (2000) PTSD model highlighting the importance of pre-trauma beliefs on trauma appraisals, world assumptions and consequent coping mechanisms. Therefore, this study has attempted to address certain concerns within religion and mental health domains by focusing on situated experiences of a sample within the tradition of Islam and demonstrating how theological considerations can be integrated into the mental health domain (Dein et al., 2012). Consequently, this facilitates health pluralism, where Eastern and Western knowledge are combined to benefit wellbeing (Tribe, 2007).

This study has also attempted to address certain methodological issues in refugee/asylum seeker research. Firstly, it looks beyond symptomology into resilience factors. What seems evident is that the presence of trauma symptoms does not necessarily impact general participant functioning, which supports previous refugee research (Jeppsson & Hjern, 2005; Tempany, 2009). Qualitative findings demonstrate that despite the presence of trauma symptoms, resilience and positive coping were found to play a significant role in participants' wellbeing and outlook on life. Secondly, the study attempted to capture the refugee/asylum seeker experience as fully as possible, by examining pre-migration, migration and post-migration experiences. This seemed to provide detailed insight into critical experiences, like the context from which they fled, migratory journeys, post-migratory context, and the psychological and behavioural impact of such experiences on participants.

### 6.2.1. Academic implications

This study may have implications from research and clinical perspectives. These are reported with caution in acknowledging limitations to extrapolation and generalisability of findings. From a research perspective, findings raise questions about the appropriateness of a quantitative approach in measuring complex concepts like world assumptions, post-trauma appraisals and religion in a non-Western sample with varying educational levels, limited psychological knowledge and trust issues given their uncertain immigration status. Further research needs to be conducted to draw more conclusive and generalisable findings.

Furthermore, the qualitative study seemed to generate a more intricate picture between religion and its influence on trauma experiences. This suggests that a more naturalistic method, allowing for the development of a relationship and a narrative approach, may be important for this sample. It highlights the importance of considering social, political and cultural contextual factors when carrying out research with refugee/asylum seeker populations. This includes an awareness of trauma experiences, sensitivity when handling these and acknowledgement of perceptions of power, trust and confidentiality. Consequently, an ethnographic approach allowing for greater contextualisation of participants' experiences may be appropriate. Moreover, the study demonstrates the co-existence of trauma symptoms as well as resilience among participants, like other refugee studies (Jeppsson & Hjern, 2005; Tempany, 2009). This further highlights the importance of research not only focusing on the psychopathology of trauma among refugees/asylum seekers but also on resilience and posttraumatic growth.

The study may also have clinical implications at a theoretical level. The qualitative study highlights the importance of Islam for trauma appraisals, coping and resilience. Should further, more extensive quantitative and qualitative research support these findings, then this could

suggest the inclusion of Islam as part of the belief construct among key cognitive processes within cognitive models of PTSD for Muslim refugees/asylum seekers (Ehlers & Clark, 2000). This could facilitate an understanding of the influence of pre-trauma beliefs, like Islam, on the trauma appraisals, world assumptions and cognitive coping for this population.

### 6.2.2. Practical implications

From a clinical practice perspective, findings may have implications at a therapeutic, service and training level. At a therapeutic level, culture is shown to influence models of mental health and explanatory health beliefs (Tribe, 2015). Therefore, should further, more extensive quantitative and qualitative, research support current qualitative findings, then this could advocate that clinicians working with Muslim refugees/asylum seekers reflect on Islam as a cultural explanatory model of trauma, its influence on appraisals and coping strategies. Such considerations could perhaps be incorporated into interventions, in line with Religious Coping Theory (Pargament, 1997). This can, for instance, be carried out through re-framing trauma experiences within Islamic notions of adversity, the afterlife and through the exploration of religious coping strategies. This may enhance understanding of trauma experiences and their consequences among Muslim refugee/asylum seeker clients, thereby offering the potential for culturally sensitive treatment. This is especially important given that ethnic minorities, including refugee populations, tend to show poor mental health service engagement (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015; Gary, 2005). Current findings may also provide insight into how practitioners can 'adapt practice to meet the needs of different groups and individuals' (HCPC, 2016, p.8), like Muslim refugee/asylum seeking populations, by drawing on Islamic concepts like reliance on (*tawakal*) and sustenance from God (*rizq*). This may serve in the

recognition of "social context and discrimination" and seek to "empower rather than control" (DCoP, 2008, p.2).

Given the poor engagement in mental health services among this population, current findings may also have implications for clinical service and training perspectives. Qualitative findings on perceptions of psychology indicate a limited knowledge of psychology and what it can offer. It is concerning that there seems to be limited evidence of therapeutic outcomes among ethnic minorities (Miranda, Nakamura & Bernal, 2003), which is arguably even more scarce among refugee/asylum seeker populations. This indicates a significant clinical gap in the current body of refugee/asylum seeker research and raises questions about the effectiveness of treatments for this population. This study examined perceptions of psychology briefly. Further research is needed to gain a more comprehensive understanding of this topic. Therefore, should further, more extensive quantitative and qualitative, research support these findings, then this could advocate the need for this population, firstly, to increase psychological awareness. Secondly, to improve communications between healthcare providers and service users, especially in terms of what psychology can offer and how services work, thereby creating awareness of access pathways. Thirdly, perhaps adopting a community-based approach, focusing on building relationships and shifting the power dynamics between healthcare provider and service users.

Such considerations may be particularly important for this population, who seem to originate from countries with limited psychological resources but who also live within a political climate of mistrust between government and immigrant populations, especially with policies like 'Hostile Environment' (Bolt, 2016) and the Counter-Terrorism and Security Act (2015). These may instil fear and create an additional barrier to accessing governmental services. It is important to acknowledge that anti-stigma programmes like the national 'Time to Change' campaign

(Mind, 2018) may play a significant role in reducing discrimination and stigma towards mental health and raising greater awareness (Evans-Lacko, Corker, Williams, Henderson & Thornicroft, 2014). Delivering this within a community-based context may be useful for this population, which may serve to "educate and empower individuals and communities" (Memon, 2016, p. 8). Indeed, research has demonstrated that community-based mental health services and alternative interventions are found to be more culturally acceptable and consequential for refugee populations (Miller & Rasco, 2004; Tribe, 2002).

Working with this population also requires multi-cultural training for practitioners. A recent study examining positive therapeutic outcomes among Counselling Psychologists working with ethnic minority clients highlighted the importance of an awareness of clients' socio-political context, the importance of cultural competence and limitations in multicultural training within counselling psychology programmes (Untanu & Dempsey, 2018). This underscores issues influencing ethical practice. Such findings, in addition to the current study, advocate specific training on the socio-cultural and political context of participants in order to effectively carryout interventions. It is suggested that training should encompass an awareness of biases, similarities and differences towards ethnic minorities (Tummala-Narra, Singer, Zhushan & Esposito, 2012), like refugees/asylum seekers. Such efforts both from a service and training perspective seem significant in engaging in ethical practice (HCPC, 2016), which forms the cornerstone of the psychological professional.

The implications outlined above may inform multicultural competence when working with Muslim refugee/asylum seeker populations, in attempting to acknowledge, understand and integrate Islam into psychological research, practice and training. It could offer the potential to widen accessibility to care, if practitioners, services and interventions are seen to comprehend

factors, like religion, considered important to refugee/asylum seeker service users. Sue et al. (1998) state "multiculturalism is about social justice, cultural democracy, and equity" (p.5). Social justice forms a foundational concept within Counselling Psychology (Toporek, Gerstein, Fouad & Israel, 2006). The many barriers to mental healthcare for refugees (Asargy & Segar, 2011; Bartolomei et al. 2016; Robertshaw et al., 2017), seems to illustrate injustices at a systemic level. This is not to deny the efforts that are being made to address this. It does, however, highlight the need for Psychologists to shift from a "microlevel to a macrolevel analysis of issues of multicultural competence" (Vera & Speight, 2003, p.269).

Multicultural competence necessitates the ability to not only understand and acknowledge cultural groups but also the capacity to be effective (Sue, 1998). Recognising effective multicultural interventions, however, requires discussions with clients and communities. Therefore, multicultural competence, encompassing social justice, needs to be developed collaboratively with its targeted service users. Indeed, the qualitative findings seem to demonstrate the willingness of participants to share their experiences and engage in dialogue. This highlights the potential for community-based research and dialogue to be conducted on a greater scale, to yield more conclusive findings on the role of religion on trauma experiences and perceptions of psychology within this population. It is hoped that the present study has provided some insight to inform and facilitate multicultural competence for this Muslim refugee/asylum seeker sample.

## 6.3. Conclusion

This mixed-methods study aimed to explore the impact of religious coping and identification on the trauma appraisals and world assumptions of Muslim refugees and asylum seekers. This topic is important given that today's society lies in the midst of the one of the world's worst forced global displacement crises (World Economic Forum, 2017), with most refugees/asylum seekers deriving from predominantly Muslim regions. Research on the impact of Islam on trauma experiences and responses remains limited (Abu-Raiya & Pargament, 2011; 2014). This research sought to address this gap.

Using Pargament's (1997) Religious Coping Theory, this study examined how Islam influences the way Muslim refugees/asylum seekers make sense of, interpret and cope with trauma experiences. The study also examined the impact of religious identification, on world assumptions and trauma appraisals, given the prevalent threat of terrorism, which seems to have influenced public and governmental perceptions towards refugees/asylum seekers (Esses et al., 2017). Furthermore, it sought to link Religious Coping Theory with cognitive (Ehlers & Clark, 2000) and world-view based trauma models (Janoff-Bulman, 1992; Pyszczynski & Kesebir, 2011; Solomon et al., 2004) to investigate if such religious facets explained substantial variance in PTSD symptoms, world assumptions and posttraumatic appraisals, within a community sample of Muslim refugees/asylum seekers. Quantitative findings demonstrate that religious coping and identification did not explain substantial variation in trauma symptoms, appraisals and world assumptions. Contrastingly, qualitative findings demonstrate the significant influence of Islam on trauma appraisals, world assumptions and coping mechanisms. This highlights the need for more extensive research to draw conclusive findings.

This study has examined a sample known to have low levels of engagement within mental healthcare. It sought to examine and understand how religion can influence mental health, so that this knowledge can be used to better inform interventions and services for such a population. While this goal seems far-reaching for this small study, it has provided a voice for an underrepresented, arguably marginalised sample within mental healthcare. It highlights the need for greater research into cultural-religious models of mental health, therapeutic outcomes and barriers to service usage among refugee/asylum seeker populations, to improve accessibility to mental health services. Such efforts are arguably especially integral from a Counselling Psychology perspective, given its foundations in social justice, which encompasses values like multicultural competence, embracing diversity and the advocacy of social issues like access to care. It is hoped that this research may offer some future directions into areas that need to be further examined, in working towards the goal of greater accessibility for this population.

# 7. Critical appraisal

No one is free from the context of their upbringing and life experiences and this inevitably influences the way in which one experiences the world. Thus, as a researcher, I reflect on my context, what brought me to this research, how this impacted the process and what I have consequently learnt from a personal and professional standpoint.

I come from Sri-Lanka. Both my parents work in the humanitarian field, so I grew up in several countries, including Indonesia, Pakistan, East-Timor, Malaysia, Vietnam, Saudi-Arabia, England and Sri-Lanka. The civil war was on-going throughout my childhood. I recall being told stories of my family being caught up in the violence between the Tamil Tigers and the government and consequently having to flee their homes. Many of my family became internally displaced, feeling to capital and re-building their lives there. During my short time in Sri-Lanka, I witnessed the consequences of this conflict, where bomb blasts, curfews and armed soldiers became a normal part of life. I recall the fear and vulnerability at times, especially when a bomb was set off, wondering if loved ones were safe and living with the uncertainty of a pervasive sense of danger. This, however, did not stop people from living their lives. There seemed a resilience, sense of fortitude and striving in the people. This was something I witnessed in several developing countries I lived in. Despite the hardships, civil strife, poverty and suffering, people's spirits seemed generally optimistic. The ability for individuals to be so resilient in the face of such adversities has always fascinated me. This drew me to examine coping factors.

The current refugee crisis has touched me at an emotional level. It took me back to my family's experience of fleeing East-Timor when the civil war broke out in 2004. While this was a difficult period for us, it seems incomparable to the prolonged distress endured by refugees/asylum seekers. Through my research I wanted to find about their experiences and

provide them with a voice, in an era where refugee/asylum seeker experiences are filtered through the media, underlined and embroiled in various political agendas.

My interest in religion stems from my own spiritual journey. I am a Muslim. Religion is something that I was born into but which I have chosen to embrace following certain life experiences. It has provided me with a source of support and meaning. My spiritual journey caused me to adopt both internal (e.g. prayers) and external (e.g. wearing the headscarf) religious practices. This has not always been the case. There were times when I struggled with faith and was unable to reconcile with paradoxical notions like God's compassion and wrath, hell and punishment. This experience influenced my interest in both positive and religious coping and their consequences for trauma experiences. In conducting this research, I had to acknowledge my bias towards religion and my emotional connectedness with the refugee/asylum seeker experience. In keeping with my psychological training, I attempted to bracket my experience and adopt a more neutral stance as I begun to conduct my research.

The research process presented difficulties from the outset. My first hurdle was finding refugee centres where I was able to conduct my research. I approached several refugee centres to recruit participants, predominantly in the Midlands as this was my base. I was informed that refugees had more pressing survival needs than research. Another concern was that of re-traumatisation, especially with many refugees/asylum seekers fleeing from religious/cultural conflicts. By arranging face-to-face meetings with centre leads, where I presented my research and addressed questions and concerns, I was fortunate to find three refugee centres willing to accommodate my research. By advocating for my research, I realised the importance of educating people about the importance of research, which forms the knowledge base for practice and intervention.

My second hurdle was the logistics of participant recruitment, within a busy environment where individuals came for their survival needs. This process presented several challenges including understanding the research, especially given that most individuals spoke Arabic. Furthermore, there were also issues around trust, confidentiality and engaging with an individual outside known social networks. Refugee centre volunteers were immensely helpful in introducing my research to various participants, I also engaged in activities held at the refugee centre to pitch my research and recruit participants. This approach seemed to validate me as a researcher and the research itself.

Through this process, I realised the importance of building relationships with potential participants, especially given that the refugee/asylum seeker journey was characterised by such mistrust (Hynes, 2003). I realised that I needed to change my stance as a researcher in dealing with this population. I could not be the neutral researcher I had set out to be, I needed to be flexible, empathetic and reflective. Diefenbach (2009) states that "science in general is a human endeavour and one cannot have ideas, assumptions, theories, and formulas without the human factor" (p. 876). It is this 'human factor', analogous with the ethos of Counselling Psychology that can be seen as a strength. Consequently, I reflected on the collectivist cultural context of participants and my own cultural experiences in coming from collectivist culture but being educated within an individualistic context. I acknowledged the importance of context, community and social relations for these participants in establishing a sense of trust. I also drew on my past experiences of conflict to connect with individuals, whilst being sensitive to what they may or may not want to disclose. Consequently, I spent time listening to participants' experiences and providing some background on myself. This seemed to aid the recruitment process. It facilitated the initiation of snowball sampling as individuals began to tell their friends

about my study. It also allowed me to recruit participants for the qualitative study, as certain participants felt comfortable enough to share their experiences in detail with me. I found this process immensely rewarding and it drove my passion and motivation for this research area. It was, however, a time consuming process. There were times, where I would only have one or two completed questionnaires after spending an entire day at the centre. This did prolong the research process.

In being aware of my myself as visibly Muslim, especially in the qualitative phase, and the influence of this on participant responses, I worked on the neutrality of my questioning. For instance, asking *if* Islam was used to cope with trauma rather than how Islam was used, which held the assumption that religion was used as a coping mechanism. I also researched the Clean Language framework, which facilitated neutrality. I carried out a couple of mock interview sessions with a researcher familiar with Clean Language as an interview process, to refine my interviewing skills. I recognise, however, that this remains an area of development for me. Additionally, my psychological training and the systemic approach, were especially useful in adopting a stance of curiosity and facilitating reflexive questioning. Furthermore, in working with an interpreter for one participant, I arranged meetings ahead of the interview to discuss the research and go through specific translation of key words like 'to cope', to ensure meanings were captured and neutrality was preserved. I also discussed the importance of neutrality for the research and asked them to avoid leading questions, taking them through a few to facilitate an understanding of how this may affect the research process. I do, however, acknowledge that my presence may have invariably influenced responses, especially in terms of negative coping and religious struggle (Abu-Raiya & Pargament, 2011).

Whilst acknowledging the potential for response biases due to my overtly Muslim identity, it did have certain advantages. It seemed to foster a connection and trust. I was able to understand individuals use of Islamic terminology and certain Arabic phrases, despite limited knowledge of Arabic. I was perhaps seen as someone from participants' in-group, which may have been fostered through Islamic concept of the *ummah*, the religious family/community. This relationship was perhaps particularly beneficial to the richness of data provided in the qualitative phase.

I was also aware of myself as a female within a predominantly male environment. It seemed that most individuals coming to refugee centres were male. Perhaps not many females made the journey, given its perilous nature. Females may also have had other priorities like children, with survival needs perhaps being left to the males. I make these assumptions based on my experience of the patriarchal society within the Middle-East, having lived in Saudi-Arabia and visited neighbouring regions. I was uncertain how it would be perceived for a female to approach males to conduct the study. I wonder if this formed an additional difficulty in recruiting participants. Those who did engage in the study seemed happy to do so, I had several positive comments from participants of both genders stating that they thought the research I was doing was important. Many participants also asked if I would be able to provide psychological support within the centre. While I signposted them to other organisations, this perhaps demonstrates the importance of community-based psychological support for this population.

Analysing my data, I must acknowledge my disappointment in the non-significance of the main quantitative findings. Reflecting on this, I acknowledged the publication bias that seems to be prevalent within the research context. It took me some time to realise that non-significance was a valid finding, alongside the awareness of my small sample size. This caused greater

reflection on the research process. I went back to my research journal, looking for factors that may have potentially influenced the study. Here, I found certain potentially influencing factors, like language and difficulties with measures. There were several individuals who were interested in the study but found the language (both Arabic and English) too complex for comprehension. This perhaps speaks to the varying educational/literacy levels of this population. Participants also reported finding it challenging to dealing with nuanced and abstract concepts. They expressed difficulties in giving discrete answers to questions. Additionally, difficulties utilising the Likert-type scale were observed, with participants ticking relevant statements until the scale was explained to them. This highlights the difficulties in quantitively examining concepts like cognitive appraisals, assumptions and religion among a cross-cultural sample.

One of the main observations during this process was the co-existence of individuals with potential post-trauma symptoms alongside an optimistic outlook on life. I found this inspirational both from a personal and professional standpoint. Personally, it put into perspective the difficulties I was experiencing in my own life and served as a motivation force. From a professional standpoint, it highlighted the importance of acknowledging resilience factors simultaneously with potentially pathological symptoms. It emphasised the exploration of cultural explanatory models of illness and wellbeing within my clinical practice. Specifically, examining the role of cultural factors in the appraisals and in coping with distress. Furthermore, it has also illustrated the willingness of participants to engage when they have an understanding of psychology and when there was a relationship between participants and the researcher. Research suggests that refugee populations have low engagement with mental health services. I do, however, wonder if we as Psychologists are doing enough to improve accessibility for this population. This perhaps warrants an approach where psychological services actively seek out

contexts that refugees/asylum seekers feel comfortable in for psychological outreach, like refugee centres or places of worship. This necessitates widening the scope of psychological outreach to community settings.

My experience in non-governmental organisations like the United Nations Development Fund for Women, has illustrated the dissemination of material aid at a community level. Perhaps such an approach can be adopted for psychological aid too. I currently work as the BME link within a psychological service. Having just begun this, I am utilising the knowledge and understanding gained through my research to begin community outreach initiatives to engage ethnic minorities, create awareness of psychology and services, understand barriers to access and create pathways for access.

This research has been allowed me to develop both personally and professionally. It has made me question the way I work. It has highlighted the importance of the cultural context to both researchers/therapists and participants/clients. It has shown me how the use of self can be an effective research and therapeutic tool. Furthermore, it has allowed me to think beyond micro-level factors impacting therapeutic outcomes, to consider how macro-level factors impact accessibility to mental health care. This has forced me to embrace the notion of social justice in my new journey working with ethnic minorities.

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# Appendix 1: Glossary of abbreviations

| | |
|---|---|
| **ABDT** | Anxiety buffer disruption theory |
| **CE** | Controllability of events |
| **CPP** | Controllability and predictability of people |
| **PCL-5** | Post-traumatic stress disorder checklist-5 |
| **PTCI** | Post trauma cognitions inventory |
| **PTG** | Post-traumatic growth |
| **PTSD** | Post-traumatic stress disorder |
| **PMIR** | Psychological measure of Islamic religiosity |
| **SDF-SF** | Social desirability scale short form |
| **SV** | Safety and vulnerability |
| **TGP** | Trustworthiness and goodness of people |
| **TMT** | Terror management theory |
| **WAQ** | World assumptions questionnaire |
| **WAS** | World assumptions scale |

# Appendix 2: Ethical approval

Date 18th January 2017

Hannah Munsoor
(Dr Nick Banks)
University of Wolverhampton
FEHW

Dear Hannah Munsoor (Dr Nick Banks)

**Re: God in Times of Adversity: An Investigation into Facets of Faiths as Cognitive Coping Mechanisms of Trauma submitted to The Faculty of Education, Health and Wellbeing Ethics Panel (Health Professions, Psychology, Social Work & Social Care)**

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your submission.

Noted:

- Grammar within the document needs scrutinising.
- The consent form should not simply ask if the participant has read it – it needs an additional statement where they confirm that they understand it.

On review your Research Proposal was passed and the Panel believes that the ethical issues inherent in your study have been adequately considered and addressed. Therefore the Panel is giving you full ethical approval for your study (**Code 1 - Approved**). We would like to wish you every success with the project.

Yours sincerely

*H Paniagua*
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – Ethics Panel

*Richard Darby*
Dr Richard Darby PhD, BSc
Chair – Ethics Panel

# Appendix 3a: English information sheet, consent form and debriefing sheet (quantitative study)

**A study of Religious Coping, identification and trauma among Muslim / Asylum Seekers**

*Please take time to read the following information carefully, before you decide to take part in this study. It is important for you to understand why the research is being done and what it will involve.*

**About the Researcher**

My name is Hannah Munsoor. I am Trainee Psychologist, working towards my Doctorate in Counselling Psychology at the University of Wolverhampton. This study forms part of my course. Please do not hesitate to ask if anything is unclear or if you would like more information.

**Purpose of Study**

- You are being invited to take part in a study examining coping methods used by refugees/ Asylum seekers of a Muslim background.
- I am interested in hearing about your experiences. By understanding this, I hope to learn more about how Muslim refugees cope with trauma. This can be used to inform treatments and models of trauma, so that they are more sensitive to your religious and cultural needs.

**What does the study involve?**

- This study requires you fill in a questionnaire booklet, which contains four questionnaires. These will look at beliefs that you have and how your beliefs shape your thinking and behaviour. This should take no longer than half an hour.
- Certain questions may bring up distressing memories. If you feel upset during or after the study, please inform me.
- Participation in this study is entirely voluntary and you are at liberty to withdraw at any time, without giving any reason for doing so.
- You will be provided with an 'important information' sheet after the study, which lists of support organizations you may wish to use.
- If you agree to participate, all information you provide on questionnaires will be treated as strictly confidential. All questionnaires will be anonymised using a unique code instead of your name. All forms will be kept locked in a secure cabinet and destroyed once the research has been completed and submitted.
- This research has been reviewed and approved by the University of Wolverhampton Ethics Sub-Committee.
- If you have any questions or concerns before or after the study, you can contact me directly on, h.munsoor@wlv.ac.uk or my research supervisor Dr Danny Hinton on d.hinton@wlv.ac.uk


**CONSENT FORM**

**Title of Project**: A study of Religious Coping, identification and trauma among Muslim / Asylum Seekers

**Name of Researcher**: Hannah Munsoor

*Please tick the boxes below if you agree with the following statements:*

1. I confirm that I have read and understand the information sheet for the study ☐
2. I have had the opportunity to ask questions ☐
3. I have had my questions answered ☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time and without giving any reason. ☐
5. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication ☐
6. I understand that the researcher may wish to publish this study and any results found, for which I give my permission ☐
7. I agree to take part in the above study. ☐

| ..... | ..... | ..... |
|---|---|---|
| Name | Date | Signature |

## Important Information

Thank you for your participate in this study. Your involvement is very much appreciated!

Due to the nature of the study, there is a possibility that some people may find certain questions within the questionnaire booklet distressing. Should you experience any distress following this study, you are advised to contact your GP or one of the organizations listed below.

Alternatively, you can contact myself or supervisor (details provided below) if you have any further questions or concerns about the study or your participation in it.

**Focusline**
*Telephone:* 0800 027 2127
*Text:* 07537 404695
Open 5pm - 1am, seven days a week, 365 days a year.

**Samaritans**
*Telephone:* 116 123 (freephone from mobiles and landlines)

**Talking Mental Health Derbyshire**
*Office address*: Ilkeston Resource Centre, Ilkeston Community Hospital, Heanor Road, Ilkeston DE7 8TL
*Telephone:* 0300 123 0542

**Hannah Munsoor (Trainee Counselling Psychologist)**

Faculty of Education, Health and Wellbeing, University of Wolverhampton, Wolverhampton, WV1 1LY. E-mail: h.munsoor@wlv.ac.uk

**Dr. Danny Hinton (Research supervisor)**

Faculty of Education, Health and Wellbeing, University of Wolverhampton, Wolverhampton, WV1 1LY. E-mail: d.hinton@wlv.ac.uk.

# Appendix 3b: Arabic information sheet, consent form and debriefing sheet (quantitative study)

**السعي المقدس: دراسة حول التآلف الديني بين المسلمين / طالبو اللجوء**

برجاء خذ وقتاً كافياً لقراءة المعلومات أدناه بعناية قبل أن تقرر المشاركة في هذه الدراسة ، و تذكر إنه من المهم بالنسبة لك أن تفهم الهدف من إجراء هذا البحث وما هي المسائل و المشكلات التي سوف يقوم بتناولها .

***نبذة عن الباحثة***

**أنا حنانة منصور. إخصائية نفسية متدربة ، و أحضر حالياً لنيل شهادة الدكتوراه في علم النفس الإرشادي في جامعة ولفرهامبتون. هذا الإستبيان يشكل جزءا من مقرر دراستي ، لذا ، فإنني آمل منك أن لا تردد في الإستفسار عن أي شئ غير واضح بالنسبة لك ، أو إذا ما كنت راغباً في مزيد من المعلومات.**

***الغرض من الدراسة***

- **أنت مدعو للمشاركة في دراسة حول فحص طرق التأقلم التي يتبعها اللاجئون / طالبو اللجوء من منطلق خلفيات إسلامية.**
- **أنني راغبة في الإطلاع على تجربتك. من خلال الحصول على تلك المعلومات ، وآمل أن أتعرف على المزيد عن كيفية تأقلم اللاجئون المسلمون مع الصدمة. و بالتالي فإن هذه المعلومات يمكن إستخدامها في إستنتاج العلاجات و نمذجة الصدمة ، و عليه، فإن تلك المعلومات تعد مطلباً حاسماً لإدراك لاحتياجاتك الدينية والثقافية.**

***ماذا تقضي الدراسة؟***

- تقتضي هذه الدراسة تعبئة كتيب استبيان يحتوي على أربعة استبيانات. و سوف تبحث هذه في معتقداتك الإيمانية وكيف تشكل تلك المعتقدات تفكيرك وسلوكك. وينبغي ألا يستغرق ذلك أكثر من نصف ساعة.
- قد تثير بعض الأسئلة ذكريات مؤلمة لديك ، فإذا ما إنتابك أي شعور بالضيق أثناء أو بعد الدراسة، يرجى إبلاغي بذلك.
- المشاركة في هذه الدراسة طوعية تماما ولك الحرية في الانسحاب في أي وقت دون إبداء أي سبب لقيامك بذلك.
- سيتم تزويدك بورقة "معلومات مهمة" بعد الدراسة، و هي تحتوي على قوائم منظمات الدعم التي قد ترغب في الإستعانة بخدماتها.

في حالة موافقتك على المشاركة، سيتم التعامل مع جميع المعلومات التي تقدمها على الإستبيانات على أنها سرية تماما. سيتم إخفاء هوية المشاركين بجميع الاستبيانات و ذلك باستخدام رمز فريد بدلا من أسم المشارك في الإستبيان. جميع نماذج الإستبيان سيتم حفظها في خزانة آمنة وتدميرها بمجرد الانتهاء من البحث وتقديمه.

- تمت مراجعة هذا البحث واعتماده من قبل اللجنة الفرعية لآداب المهنة لجامعة ولفرهامبتون.
- إذا كان لديك أي أسئلة أو استفسارات قبل أو بعد الدراسة، يمكنك الاتصال بي مباشرة على، h.munsoor@wlv.ac.uk
أو بالمشرف البحثي الدكتور نك بانكس
على ، d.hinton@wlv.ac.uk

نموذج الإفادة بالموافقة

*عنوان المشروع: التعامل مع الصدمة: دراسة سردية للمرأة السودانية*

أسم الباحثة :حنانة منصور

يرجى وضع علامة في المربعات أدناه إذا كنت موافقاً على العبارات التالية:

| | |
|---|---|
| 1. أقر بأنني قرأت وفهمت ورقة المعلومات الخاصة بالدراسة | ☐ |
| 2. لقد أتيحت لي الفرصة لطرح الأسئلة | ☐ |
| 3. لقد تم الإجابة على أسئلتي | ☐ |
| 4. وأنا أفهم أن مشاركتي طوعية ز أنه يحق لي الانسحاب في أي وقت ودون إبداء أي سبب. | ☐ |
| 5. أفهم أن البيانات الخاصة بي سيتم تخزينها بشكل آمن وسري أن شخصي لن يكون معرفاً في أي تقرير أو نشرة | ☐ |
| 6. وأنا أفهم أن الباحث قد يرغب في نشر هذه الدراسة وأي نتائج وجدت، والتي أعطي إذني | ☐ |
| 7. أوافق على المشاركة في الدراسة المذكورة أعلاه. | ☐ |

| | | |
|---|---|---|
| ..... | ..... | ..... |
| الأسم | التاريخ | التوقيع |

***معلومات هامة***

**شكرا على موافقتك على المشاركة في هذا البحث وهي محل تقدير كبير لدينا!**
**نظرا لطبيعة الدراسة، هناك احتمال أن يجـد بعضاً من الأشخاص أن بعض الأسئلة المضمنة في كتيب الاستبيان مفجعة. فإذا ما عانيت أي إزعاج بعد هذه الدراسة، فإنني أنصح بالاتصال بطبيبك العام أو إحدى المنظمات المدرجة أدناه.**
**بدلا من ذلك، يمكنك الاتصال بالمشرف على البحث أو بشخصي (التفاصيل مبينة أدناه) إذا ما كان لديك أي أسئلة أو استفسارات أخرى حول الدراسة أو مشاركتك فيها.**

***فوكس لاين***

هاتف: 0800 027 2127
إتصال نصي: 07537 404695
من 5 مساء إلى 1 صباحا، سبعة أيام في الأسبوع، 365 يوما في السنة.

***السامريون***

الهاتف: 116 123(الهاتف المجاني من الهواتف النقالة والهواتف الأرضية)

***الصحة العقلية الناطقة ديربيشاير***

عنوان المكتب: إلكستون ريسورس سنتر ، اليكستون كمينتي هوسبيتل، شارع هينور ، إلكستون DE7 8TL
الهاتف: 0300 123 0542

حنانة منصور (أخصائي علم النفس متدربة)
كلية التربية والصحة والرفاه، جامعة ولفرهامبتون، ولفرهامبتون، WV1 1LY
بريد اليكتروني:h.munsoor@wlv.ac.uk

الدكتور نك بانكس (أخصائي علم النفس السريري)
كلية التربية والصحة والرفاه، جامعة ولفرهامبتون، ولفرهامبتون ، WV1 1LY
بريد اليكتروني: d.hinton@wlv.ac.uk

# Appendix 3c: Information sheet, consent form and debriefing sheet (qualitative phase)

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE • INNOVATION • ENTERPRISE

## A study of religious coping, identification and trauma among Muslim Refugees/ Asylum Seekers

*Please take time to read the following information carefully, before you decide to take part in this study. It is important for you to understand why the research is being done and what it will involve.*

**What is the study about?**
You are being invited to take part in a study examining coping methods used by refugees/ Asylum seekers of a Muslim background. I am interested in hearing about your experiences. By understanding this, I hope to learn more about how Muslim refugees cope with trauma. This can be used to inform treatments and models of trauma, so that they are more sensitive to your religious and cultural needs.

**What will I have to do?**
In this study you will be asked to share your experiences of how you coped in coming to this to this country, as well as how your beliefs shape your thinking and behaviour. This study will take approximately one hour. You will be given a copy of the information sheet and signed consent form, should you choose to participate in the study.

**What are the potential benefits and risks of taking part?**

While this study may not have direct benefits for you at present, by finding out about coping responses towards trauma, this study hopes to influence and improve trauma interventions within this region.

There are no risks to you in taking part, outside of those you would experience in everyday life. Your participation, however, may cause you to remember things that you may find upsetting. If this occurs, the researcher will ask you if you want to continue to participate in the interview. Any decision you make will be respected. In this case, the researcher will also ask for your permission to refer you onto a Psychologist.

**Will my information be kept confidential?**
Yes, if you agree to participate, all information you provide on the interview will be treated as strictly confidential. All material will be given a unique code that will be used in subsequent data analysis and any reports resulting from this data will be anonymised. All audio recordings will be kept confidentially and stored securely on a password-protected laptop. Only the researchers working on the study will have access to the information. You will not be identifiable in any publication or report as the data will be grouped together and all identifying information will be removed. Interview recordings will be deleted following the completion of my doctoral programme. You have the right to ask for the interview to deleted at any point during or after the interview.

**Who has reviewed the study?**

This study has been reviewed and approved by the University of Wolverhampton's ethics committee.

**Do I have to take part in the study?**
Participation in this study entirely voluntary and you are at liberty to withdraw up until your data has been analysed, without giving any reason for doing so. The researchers contact details will be provided to you for this reason.

**Who do I contact if I have a question or concerns?**
If you have any questions or concerns before or after the study, you can contact me directly on, h.munsoor@wlv.ac.uk or my research supervisor on d.hinton@wlv.ac.uk.

*Thank you for taking the time to read this. The researcher will be happy to answer your questions. If you wish to participate, please turn over for the consent sheet.*


**CONSENT FORM**

**Title of Project**: A study of religious coping, identification and trauma among Muslim Refugees/ Asylum Seekers

**Name of Researcher**: Hannah Munsoor

*Please tick the boxes below if you agree with the following statements:*

1. I confirm that I have read and understand the information sheet for the study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw up until commencement of data analysis, without giving any reason. ☐
3. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication ☐
4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission ☐
5. I agree for my interview to be audio recorded and for the data to be used for the purpose of this study. ☐
6. I agree to take part in the above study. ☐

| ..... | ..... | ..... |
|---|---|---|
| Name | Date | Signature |
| ..... | ..... | ..... |
| Researcher | Date | Signature |

**Appendix 4a: English questionnaire booklet**

# Questionnaire booklet

Professional Doctorate in Counselling Psychology, University of Wolverhampton

Hannah Munsoor

**RESEARCH STUDY: A STUDY OF RELIGIOUS COPING, IDENTIFICATION AND TRAUMA AMONG MUSLIM REFUGEES AND ASYLUM SEEKERS**

**Demographic information**

- Age (years): _____
- Gender: Female Male Other
- Marital status: Single Married/ In a relationship Divorced Widowed
- Country of Origin: _____
- Education: Primary school Secondary/ high school Higher Education (please specify) _____
- Religious sect: Sunni Shiia Other (please state): _____
- When did you leave your home country (Month/Year)? _____
- Refugee/ Asylum seeker

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem <u>in the past month.</u>

| **In the past month, how much were you bothered b** | **Not at a** | **A little b** | **Moderately** | **Quite a bi** | **Extremely** |
|---|---|---|---|---|---|
| 1. Repeated, disturbing, and unwanted memories of t stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 2. Repeated, disturbing dreams of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling very upset when something reminded you the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 5. Having strong physical reactions when something reminded you of the stressful experience (e.g. heart pounding, trouble breathing, sweating)? | 0 | 1 | 2 | 3 | 4 |
| 6. Avoiding memories, thoughts, or feelings related t the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 7. Avoiding external reminders of the stressful experience (e.g. people, places, conversations, activities, objects or situations)? | 0 | 1 | 2 | 3 | 4 |
| 8. Trouble remembering important parts of the stress experience | 0 | 1 | 2 | 3 | 4 |
| 9. Having strong negative beliefs about yourself, othe people or the world (for example, having thoughts su as: I am bad, there is something seriously wrong with me no one can be trusted, the world is completely dangerous)? | 0 | 1 | 2 | 3 | 4 |
| 10. Blaming yourself or someone else for the stressfi experience or what happened after it? | 0 | 1 | 2 | 3 | 4 |
| 11. Having strong negative feelings such as fear, horror, anger, guilt or shame? | 0 | 1 | 2 | 3 | 4 |
| 12. Loss of interest in activities that you used to enjo | 0 | 1 | 2 | 3 | 4 |
| 13. Feeling distant or cut off from other people? | 0 | 1 | 2 | 3 | 4 |
| 14. rouble experiencing positive feelings (e.g. being unable to feel happiness or have loving feelings for people close to you)? | 0 | 1 | 2 | 3 | 4 |
| 15. Irritable behaviour, angry outbursts, or acting aggressively? | 0 | 1 | 2 | 3 | 4 |
| 16. Taking too many risks or doing things that could cause you harm? | 0 | 1 | 2 | 3 | 4 |
| 17. Being “super alert” or watchful or on guard? | 0 | 1 | 2 | 3 | 4 |
| 18. Feeling jumpy or easily startled? | 0 | 1 | 2 | 3 | 4 |
| 19. Having difficulty concentrating? | 0 | 1 | 2 | 3 | 4 |
| 20. Trouble falling or staying asleep? | 0 | 1 | 2 | 3 | 4 |

We are interested in the kind of thoughts, which you may have had after a traumatic experience/ stressful life event. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or

DISAGREE with each by putting the appropriate number between 1 & 7 in the box to the right of the statement. People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

| *1* | *2* | *3* | *4* | *5* | *6* | *7* |
|---|---|---|---|---|---|---|
| *totally disagree* | *disagree very much* | *disagree slightly* | *neutral* | *agree slightly* | *agree very much* | *totally agree* |

| | | |
|---|---|---|
| 1 | The event happened because of the way I acted | |
| 2 | I can't trust that I will do the right thing | |
| 3 | I am a weak person | |
| 4 | I will not be able to control my anger and will do something terrible | |
| 5 | I can't deal with even the slightest upset | |
| 6 | I used to be a happy person but now I am always miserable. | |
| 7 | people can't be trusted | |
| 8 | I have to be on guard all the time | |
| 9 | I feel dead inside | |
| 10 | you can never know who will harm you | |
| 11 | I have to be especially careful because you never know what can happen next | |
| 12 | I am inadequate | |
| 13 | If I think about the event, I will not be able to handle it | |
| 14 | the event happened to me because of the sort of person I am | |
| 15 | my reactions since the event mean that I am going crazy | |
| 16 | I will never be able to feel normal emotions again | |
| 17 | the world is a dangerous place | |
| 18 | somebody else would have stopped the event from happening | |
| 19 | I have permanently changed for the worse | |
| 20 | I feel like an object, not like a person | |
| 21 | Somebody else would not have gotten into this situation | |
| 22 | I can't rely on other people | |
| 23 | I feel isolated and set apart from others | |
| 24 | I have no future | |
| 25 | I can't stop bad things from happening to me | |
| 26 | people are not what they seem | |
| 27 | my life has been destroyed by the trauma | |
| 28 | there is something wrong with me as a person | |
| 29 | my reactions since the event show that I am a lousy coper | |
| 30 | there is something about me that made the event happen | |
| 31 | I feel like I don't know myself anymore | |
| 32 | I can't rely on myself | |
| 33 | Nothing good can happen to me anymore | |

**Psychological Measure of Islamic Religiousness (PMIR)**

Islamic Identification Subscale

**Please circle the answer that best indicates your reaction to each the following statements.**

1. *I pray because I enjoy it*

Not at all true (1) Usually not true (2) Usually true (3) Very true (4)

Not applicable

2. *I pray because I find it satisfying*

Not at all true (1) Usually not true (2) Usually true (3) Very true (4)

Not applicable

3. *I read the Holy Qura'n because I feel that Allah is talking to me when I do that*

Not at all true (1) Usually not true (2) Usually true (3) Very true (4)

Not applicable

4. *I read the Holy Qura'n because I find it satisfying*

Not at all true (1) Usually not true (2) Usually true (3) Very true (4)

Not applicable

5. *I fast in Ramadan because when I fast I feel close to Allah*

Not at all true (1) Usually not true (2) Usually true (3) Very true (4)

Not applicable

Islamic Positive Religious Coping Subscale

1. *When I face a problem in life, I look for a stronger connection with Allah*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

2. *When I face a problem in life, I consider that a test from Allah to deepen my belief*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

3. *When I face a problem in life, I seek Allah's love and care*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

4. *When I face a problem in life, I read the Holy Qura'n to find consolation*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

5. *When I face a problem in life, I ask for Allah's forgiveness*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

6. *When I face a problem in life, I remind myself that Allah commanded me to be patient*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

7. *When I face a problem in life, I do what I can and put the rest in Allah's hands*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

<u>Punishing Allah Reappraisal Subscale</u>

**Please circle the answer that best indicates your reaction to each the following statements.**

1. *When I face a problem in life, I believe that I am being punished by Allah for bad actions I did*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

*2. When I face a problem in life, I wonder what I did for Allah to punish me*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

3. *When I face a problem in life, I feel punished by Allah for my lack of devotion*

I do not do this at all (1) I do this a little (2)

I do this a medium amount (3) I do this a lot (4)

Islamic Religious Struggle Subscale

**Please circle the answer that best indicates your reaction to each the following statements.**

1. *I find myself doubting the existence of Allah*

Never (0) Rarely (1) Sometimes (2) Often (3) Very often (4)

2. *I find some aspects of Islam to be unfair*

Never (0) Rarely (1) Sometimes (2) Often (3) Very often (4)

3. *I find myself doubting the existence of afterlife*

Never (0) Rarely (1) Sometimes (2) Often (3) Very often (4)

4. *I think that Islam does not fit the modern time*

Never (0) Rarely (1) Sometimes (2) Often (3) Very often (4)

5. *I doubt that the Holy Qura'n is the exact words of Allah*

Never (0) Rarely (1) Sometimes (2) Often (3) Very often (4)

6. *I feel that Islam makes people intolerant*

Never (0) Rarely (1) Sometimes (2) Often (3) Very often (4)

Please read each statement carefully and tell us how much you AGREE or DISAGREE with each by putting the appropriate number between 1 & 6 in the box to the right of the statement. There are no right or wrong answers to these state statements.

| *1* | *2* | *3* | *4* | *5* | *6* |
|---|---|---|---|---|---|
| *Strongly agree* | *Agree* | *Slightly agree* | *Slightly disagree* | *Disagree* | *Strongly disagree* |

| | |
|---|---|
| 1. Most people can be trusted | |
| 2. I don't feel in control of the events that happen to me | |
| 3. You usually can know what is going to happen in your life | |
| 4. It is difficult for me to take most of what people say at face-value | |
| 5. It is very difficult to know what others are thinking | |
| 6. Anyone can experience a very bad event | |
| 7. People often behave in unpredictable ways | |
| 8. People are less safe than they usually realize | |
| 9. For the most part, I believe people are good | |
| 10. I have a great deal of control over what will happen to me in my life | |
| 11. You never know what's going to happen tomorrow | |
| 12. Other people are usually trustworthy | |
| 13. People's lives are very fragile | |
| 14. It is hard to know exactly what motivates another person | |
| 15. Most people cannot be trusted | |
| 16. People fool themselves into feeling safe | |
| 17. It is hard to understand why people do what they do | |
| 18. Most of what happens to me happens because I choose it | |
| 19. Terrible things might happen to me | |
| 20. It is ultimately up to me to determine how events in my life will happen | |

| | |
|---|---|
| 21. It can be very difficult to predict other people's behaviour | |
| 22. What people say and what they do are often very different things. | |

Please read the following statements carefully and circle the appropriate response.

| | | |
|---|---|---|
| **1.** It is sometimes hard for me to go on with my work if I am not encouraged. | **True** | **False** |
| **2.** I sometimes feel resentful when I don't get my way. | **True** | **False** |
| **3.** On a few occasions, I have given up doing something because I thought too little of my ability. | **True** | **False** |
| **4.** There have been times when I felt like rebelling against people in authority even though I knew they were right. | **True** | **False** |
| **5.** No matter who I'm talking to, I'm always a good listener. | **True** | **False** |
| **6.** There have been occasions when I took advantage of someone. | **True** | **False** |
| **7.** I'm always willing to admit it when I make a mistake. | **True** | **False** |
| **8.** I sometimes try to get even rather than forgive and forget. | **True** | **False** |
| **9.** I am always courteous, even to people who are disagreeable. | **True** | **False** |
| **10.** I have never been irked when people expressed ideas very different from my own. | **True** | **False** |
| **11.** There have times when I was quite jealous of the good fortune of others. | **True** | **False** |
| **12.** I am sometimes irritated by people who ask favours of me. | **True** | **False** |
| **13.** I have never deliberately said something that hurt someone's feelings. | **True** | **False** |

**Appendix 4b: Arabic questionnaire booklet**

# جامعــة ولفرهــامبتون

# Questionnaire booklet

درجة الدكتوراه المهنية في علم النفس الإرشادي

*كتيب الإستبيان*

## دراسة بحثية

**النزوح المقدس : دراسة حول التآلف الديني بين المسلمين / طالبو اللجوء**

- السن: _____(سنوات)
- الحنس :أنثي ذكر
- الحالة الإجتماعية :عازب/ عازبة متزوج / في علاقة مطلق/ مطلقة أرمل/ أرملة
- الموطن _____ :
- التعليم : مدرسة إبتدائية ثانوية /عليا مدرسة تعليم عالي (يرجي التحديد)

_____

- الطائفة الدينية :سني شيعة :( أخري) يرجي التحديد_____
- متي غادرت موطنك (الشهر/السنة) ؟_____
- اللائذ/ طالب لجوء؟

وفيما يلي قائمة بالمشاكل التي يتعرض لها الأشخاص في بعض الأحيان كرد فعلاً ناتج من تجربة مزعجة جدا. و أنت / أنتي تضع/ تضعين في الإعتبار أسوأ ما حدث لك/لكي ، يرجى قراءة كل مشكلة بعناية ثم القيام برسم دائرة حول أحد الأرقام في يمين العبارة للإشارة إلى مقدار ما تسببت فيه تلك المشكلة لك /لكي من إرباك <u>في الشهر الماضي</u>.

| في الشهر الماضي، كم مرة تعرضت للإزعاج بسبب: | على الإطلاق | قليلاً | بشكل معتدل | جداً | كثيراً |
|---|---|---|---|---|---|
| 1. تكرار، ذكريات مزعجة، وغير مرغوب فيها عن التجربة مزعجة | 0 | 1 | 2 | 3 | 4 |
| 2. أحلام مزعجة متكررة، عن التجربة المفزعة؟ | 0 | 1 | 2 | 3 | 4 |
| شعور فجائي أو تصرف كما لو أن التجربة المفزعة تحدث فعلاً مرة أخرى (كما لو أنك عدت الي نفس المكان و تعايشها بالفعل)؟ 3 | 0 | 1 | 2 | 3 | 4 |
| الشعور بالضيق الشديد عندما يذكرك شيء ما بالتجربة المفزعة ؟ 4. | 0 | 1 | 2 | 3 | 4 |
| وجود ردود فعل بدنية عنيفة عندما يذكرك شيء بتجربتك المفزعة (على سبيل المثال، إضطراب القلب ، صعوبة في التنفس، والتعرق)؟ 5 | 0 | 1 | 2 | 3 | 4 |
| 6. تجنب الذكريات، والأفكار، أو المشاعر المتعلقة بالتجربة المفزعة ؟ | 0 | 1 | 2 | 3 | 4 |
| ب المؤثرات الخارجية التي تذكر بالتجربة المفزعة (مثال ، أشخاص، أماكن، محادثات، أنشطة، أشياء، أو ف)؟ 7 | 0 | 1 | 2 | 3 | 4 |
| مشكلة تذكر أجزاء مهمة من التجربة المفزعة؟ 8. | 0 | 1 | 2 | 3 | 4 |
| 9. تفادي أشياء خارجية تعيد الي ذاكرتك ملامح من تجارب اليمة | 0 | 1 | 2 | 3 | 4 |
| إلقاء اللوم على نفسك أو على شخص آخر بأنه كان سبباً في حدوث تجربة مريرة أو ما حدث بعدها ؟.10 | 0 | 1 | 2 | 3 | 4 |
| وجود مشاعر سلبية قوية مثل الخوف ، الرعب ، الغضب، الذنب، أو العار؟ .11, | 0 | 1 | 2 | 3 | 4 |
| 12.فقدان الاهتمام بالأنشطة التي كنت تستمتع بها؟ | 0 | 1 | 2 | 3 | 4 |
| 13.الشعور بالبعد عن الآخرين أو إنقطاع العلاقة معهم ؟ | 0 | 1 | 2 | 3 | 4 |
| معاناة مشكلة عدم إيجاد مشاعر إيجابية (على سبيل المثال، القدرةعلى الشعور بالسعادة أو الشعور بمحبة الأشخاص القربين)؟.14 | | | | | |
| 15.السلوك العصبي، إنفجار نوبات غضب ، أو التصرف بعدوانية؟ | 0 | 1 | 2 | 3 | 4 |
| الإقدام على فعل الكثير من المخاطر أو القيام بالأشياء التي يمكن أن تسبب ضرراً؟.16 | 0 | 1 | 2 | 3 | 4 |
| 17.تكون في حالة "إنتباه شديد" و ترقب و تأهب؟ | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| شعور بسرعة الإهتياج سريع الإصابة بالروع ؟.18 | 0 | 1 | 2 | 3 | 4 |
| إيجاد صعوبة في التر.19 | 0 | 1 | 2 | 3 | 4 |
| إضطرابات النوم؟.20 | 0 | 1 | 2 | 3 | 4 |

نحن مهتمون في هذا النوع من الأفكار، والتي قد تكون لديك بعد تجربة مفزعة / موقف مفزع. وفيما يلي عدد من البيانات التي قد تكون أو لا تكون ممثلة لتفكيرك. يرجى قراءة كل بيان بعناية و من ثم أفيدنا عن مدى **موافقتك** أو عدم **موافقتك** مع كل منها و ذلك من رسم شكل مربع حول الرقم المناسب من 1 و 7 في المربع على يمين البيان. الناس يتفاعلون مع الأحداث الصادمة بطرق مختلفة. لا توجد إجابات صحيحة أو خاطئة على هذه التصريحات.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *أوافق تماماً* | *أوافق بشدة* | *أوافق قليلاً* | *محايد* | *لا أوافق قليلاً* | *لا أوافق بشدة* | *افق الإطلاق* | |
| 1. | وقع الحدث نتيجة للطريقة التي تصرفت بها | | | | | | |
| 2. | لا أستطيع أن أثق في أنني سوف أفعل الشيء الصحيح | | | | | | |
| 3. | أنا شخص ضعيف | | | | | | |
| 4. | إنني لا أستطيع السيطرة على غضبي و سوف أقوم بفعل مروع | | | | | | |
| 5. | إنني لا أستطيع حتي السيطرة على أقل إضطراب | | | | | | |
| 6. | في السابق كنت شخصاً سعيداًو لكنني الآن أعاني دائماً من الكآبة | | | | | | |
| 7. | الناس غير جديرون بالثقة | | | | | | |
| 8. | يجب أكون دائماً في حالة تأهب | | | | | | |
| 9. | في دواخل نفسي أشعر بأنني فاقد للحياة | | | | | | |
| 10. | أنت لن يكون بوسعك أن تدرك من هو من قد يصيبك بالأذي | | | | | | |
| 11. | يجب أن تكون حذرا على نحو إستثنائي لأنك لا تعرف أبدا ما يمكن أن يحدث بعد ذلك | | | | | | |
| 12. | أنا لست مؤهلاً | | | | | | |
| 13. | إذا جلست إستعيد ذكري الحادث ، فلن أستطيع أن أتمالك مشا | | | | | | |
| 14. | لقد حدث لي ذلك الحادث لأن طبيعة شخصيتي كذلك | | | | | | |
| 15. | ردود فعلي منذ هذا الحدث تعني أنني ماضي الي الإصابة بالجنون | | | | | | |
| 16. | سوف لن أكون قادراً على إستعادت إحساسي الطبيعي مرة أخري | | | | | | |
| 17. | هذا العالم مكان خطر | | | | | | |
| 18. | لو كان هناك شخص آخر في مكاني لكان قادراً على منع وقوع تلك الحادثة | | | | | | |
| 19. | أنني قد تغيرت الي الأسوء بصفة دائمة | | | | | | |
| 20. | أصبحت أشعر و كأنني جماد من الجمادات ، و ليس كإنسان | | | | | | |
| 21. | لو كان هناك شخص آخر في مكاني ما كان له أن يتعرض لمثل تلك الحادثة | | | | | | |
| 22. | أنا لا أستطيع أن أثق في الآخرين | | | | | | |
| 23. | أشعر بالعزلة و منفصل عن الناس | | | | | | |
| 24. | انا ليس لي مستقبل | | | | | | |
| 25. | أنا لا أستطيع أن أمنع حدوث الأمور السيئة لي | | | | | | |
| 26. | الناس ليسوا كما يبدون من مظاهرهم | | | | | | |
| 27. | لقد تدمرت حياتي بسبب الصدمة | | | | | | |
| 28. | هناك شئ خطأ في شخصي كإنسان | | | | | | |
| 29. | لقد أصبحت ردود فعلي منذ الحادثة تظهر أنني شخص حقير | | | | | | |
| 30. | هناك شئ في شخصي جعل الحادثة تقع على | | | | | | |
| 31. | أشعر و كأنني صرت لا أعرف نفسي أبداً | | | | | | |
| 32. | أنا لا أستطيع أن أثق في نفسي | | | | | | |
| 33. | ليس هناك شيء جيد يمكن أن يحدث لي بعد الآن | | | | | | |

# المقياس السيكولوجي لأنماط التدين الإسلامي

# Psychological Measure of Islamic Religiousness (PMIR)


## هشام أبو ريا


## التدين داخليّ المنشأ (Religious Identification)

**رجاءً، أحط بدائرة الجواب الذي يعبر بأفضل صورة عن ردك على العبارات التالية:**

**1. أصلي لأني أتمتع بالصلاة**

لا أصلي (0) غير صحيح على الإطلاق (1) غير صحيح (2) صحيح عادةً (3) صحيح جداً (4)

**2. أصلي لأنني أشعر باكتفاء بالصلاة**

لا أصلي (0) غير صحيح على الإطلاق (1) غير صحيح (2) صحيح عادةً (3) صحيح جداً (4)

**3. أقرأ القرآن لأنني أشعر أن الله يكلمني عندما أفعل ذلك**

لا أقرأ القرآن (0) غير صحيح على الإطلاق (1) غير صحيح (2) صحيح عادةً (3) صحيح جداً (4)

**4. أقرأ القرآن لأني أجد في قراءة القرآن اكتفاءً**

لا أقرأ القرآن (0) غير صحيح على الإطلاق (1) غير صحيح (2) صحيح عادةً (3) صحيح جداً (4)

**5. أذهب إلى المسجد لأنني أعتقد أن المسجد هو بيت الله**

لا أذهب إلى المسجد (0) غير صحيح على الإطلاق (1) غير صحيح (2) صحيح عادةً (3) صحيح جداً (4)

**6. أصوم في رمضان لأنني عندما أصوم أشعر بالقرب من الله**

لا أصوم (0) غير صحيح على الإطلاق (1) غير صحيح (2) صحيح عادةً (3) صحيح جداً (4)

## المواجهة الدينية الإيجابية (Positive Religious Coping)

**رجاءً، أحط بدائرة الجواب الذي يعبر بأفضل صورة عن ردك على العبارات التالية:**

**1. عندما أواجه مشكلة في حياتي أبحث عن صلة أقوى مع الله**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

**2. عندما أواجه مشكلة في حياتي أعتبر ذلك بلاءً من الله لترسيخ ايماني**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

**3. عندما أواجه مشكلة في حياتي ألجأ الى حب الله ورعايته**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

**4. عندما أواجه مشكلة في حياتي أقرأ القرآن لأواسي نفسي**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

**5. عندما أواجه مشكلة في حياتي أطلب مغفرة الله**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

**6. عندما أواجه مشكلة في حياتي أذكّر نفسي أن الله أمرني أن أكون صبوراً**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

**7. عندما أواجه مشكلة في حياتي أعمل ما أستطيع عمله وأترك الباقي لله**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

## الله كمعاقب (Punishing Allah Reappraisal)

**رجاءً، أحط بدائرة الجواب الذي يعبر بأفضل صورة عن ردك على العبارات التالية:**

**1. عندما أواجه مشكلة في حياتي أؤمن أنني أعاقَب على أعمال سيئة قمت بها**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

**3. عندما أواجه مشكلة في حياتي أظن أن الله يعاقبني على ذَنب اقترفته**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

**3. عندما أواجه مشكلة في حياتي أشعر أن الله يعاقبني على عدم الإخلاص في عبادته**

لا أفعل ذلك إطلاقاً (1) لا أفعل ذلك كثيراً (2) أفعل ذلك بشكل متوسط (3) أفعل ذلك كثيراً (4)

## الصراع الديني (Religious Struggle)

**رجاءً، أحط بدائرة الجواب الذي يعبر بأفضل صورة عن ردك على العبارات التالية:**

**1. عندما أواجه مشكلة في حياتي أجد نفسي أشك بوجود الله**

ولا مرة (0) نادراً (1) في بعض الأحيان (2) في كثير من الأحيان (3) في أوقات متقاربة (4)

**3. عندما أواجه مشكلة في حياتي أجد بعض جوانب الإسلام غير عادلة**

ولا مرة (0) نادراً (1) في بعض الأحيان (2) في كثير من الأحيان (3) في أوقات متقاربة (4)

**3. عندما أواجه مشكلة في حياتي أجد نفسي أشك بوجود الآخرة**

ولا مرة (0) نادراً (1) في بعض الأحيان (2) في كثير من الأحيان (3) في أوقات متقاربة (4)

**4. عندما أواجه مشكلة في حياتي أفكر أن الإسلام لا يلائم الحياة الحديثة**

ولا مرة (0) نادراً (1) في بعض الأحيان (2) في كثير من الأحيان (3) في أوقات متقاربة (4)

**5. عندما أواجه مشكلة في حياتي أشك أن القرآن هو كلمات الله المنزلة**

ولا مرة (0) نادراً (1) في بعض الأحيان (2) في كثير من الأحيان (3) في أوقات متقاربة (4)

**6. عندما أواجه مشكلة في حياتي أفكر أن الإسلام يجعل الناس محدودي التفكير وغير متسامحين**

ولا مرة (0) نادراً (1) في بعض الأحيان (2) في كثير من الأحيان (3) في أوقات متقاربة (4)

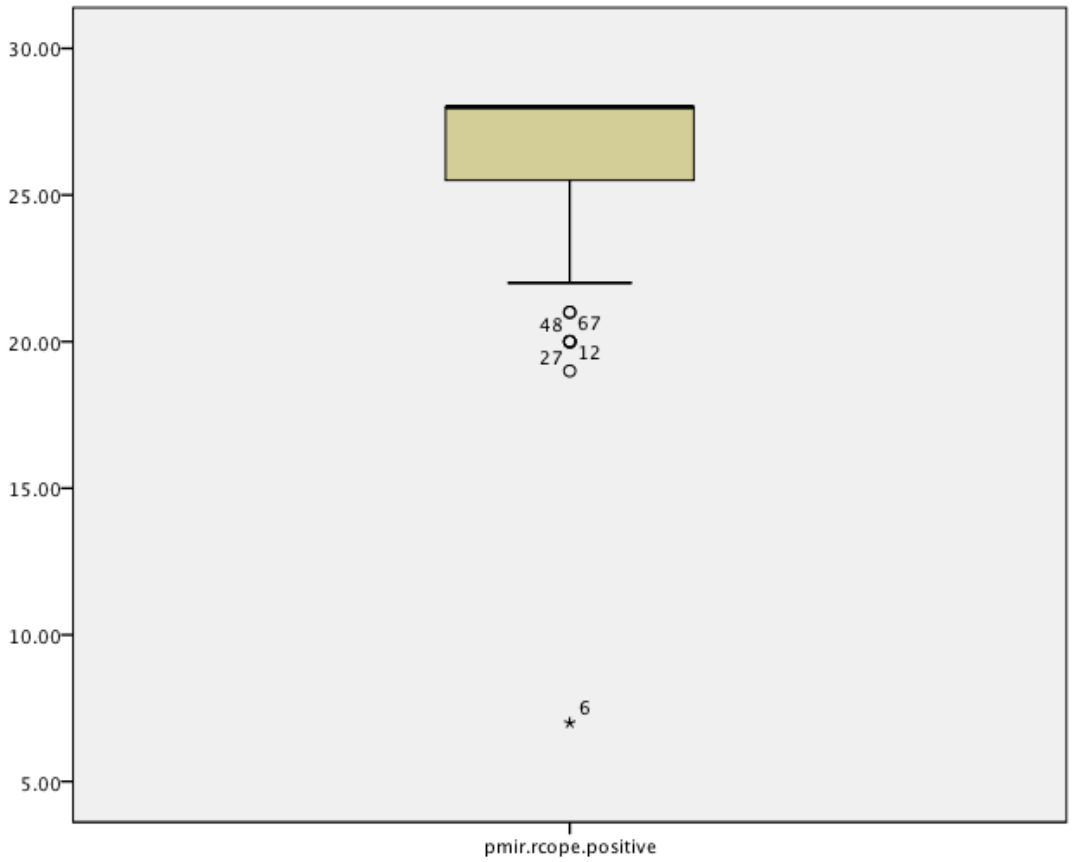
يرجى قراءة كل مشكلة بعناية و من ثم أفيدنا عن مدى موافقتك أو عدم موافقتك على كل بكتابة الرقم المناسب من 1 ، 6 في الخانة على يمين البيان . الناس يتفاعلون مع الأحداث الصادمة بطرق مختلفة. لا توجد إجابات صحيحة أو خاطئة على هذه التصريحات

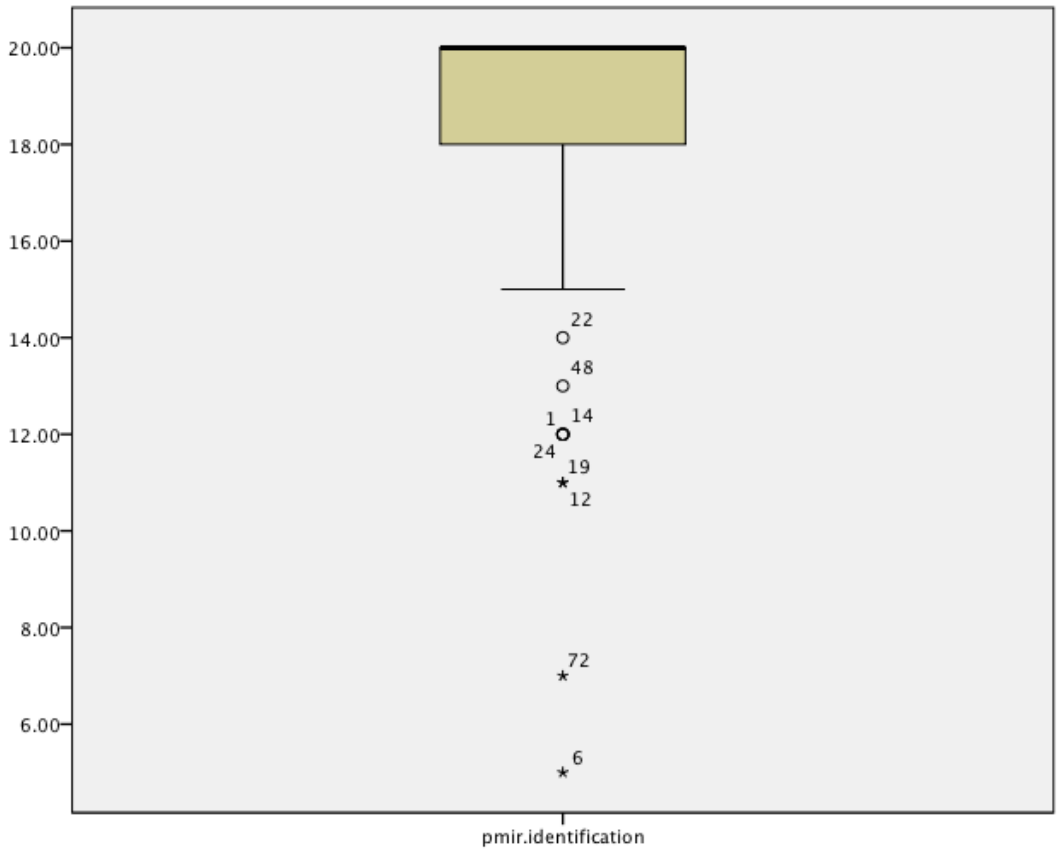
| *لا أوافق بشدة* | *افق* | *لا أوافق قليلاً* | *أوافق قليلاً* | *أوافق* | *أوافق* |
|---|---|---|---|---|---|

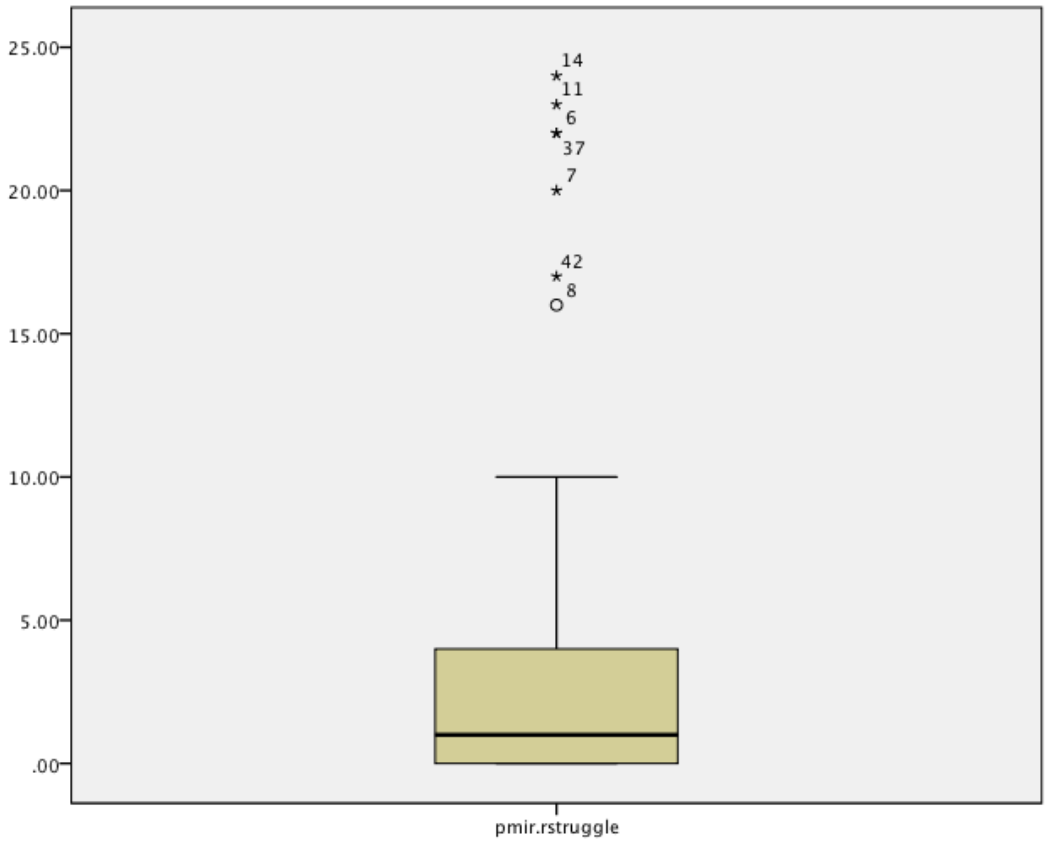
| | |
|---|---|
| 23. معظم الناس يمكن الوثوق بهم | |
| 24. أنا لا أحس بالسيطرة على الأحداث التي تحدث لي | |
| 25. يمكنك عادة معرفة ما سيحدث في حياتك | |
| 26. من الصعب بالنسبة لي أن أخذ معظم ما يقوله الناس بظاهر قولهم | |
| 27. من الصعب جدا معرفة ما يفكر فيه الآخرون | |
| 28. يمكن لأي شخص أن يمر بتجربة حادثة سيئة للغاية | |
| 29. الناس غالبا ما يتصرفون بطرق غير متوقعة | |
| 30. الناس عادة ما يكونون أقل أمانا مما هم يدركون | |
| 31. في معظم الأحوال ، الناس جيدون | |
| 32. لدي قدر كبير من السيطرة على ما سيحدث لي في حياتي | |
| 33. أنت لا تعرف أبدا ما سيحدث غدا | |
| 34. الناس الآخرون عادة ما يكونون جديرون بالثقة | |
| 35. حياة الناس سريعة الزوال للحد البعيد | |
| 36. من الصعب معرفة بالضبط ما هو الشئ الذي يحفز شخصاً آخراً | |
| 37. أغلب الناس لا يمكن الوثوق بهم | |
| 38. الناس يخدعون أنفسهم بالشعور بأنهم آمنون | |
| 39. من الصعب أن نفهم لماذا يفعل الناس ما يفعلونه | |
| 40. معظم ما حدث لي كان بإختياري | |
| 41. قد تحدث لي أشياء مفزعة | |
| 42. في نهاية المطاف أن الأمر متروك لي لتحديد كيفية وقوع الأحداث في حياتي | |
| 43. قد يكون من الصعب جدا التنبؤ بسلوك الآخرين | |
| 44. ما يقوله الناس غالبا ما يكون خلافاً لما يفعلونه. | |

| | | |
|---|---|---|
| 1. إنه يصعب على أحيانا أن أباشر الي عملي إذا لم أجد تشد | صحيح | |
| 2. أحيانا أشعر بالاستياء عندما لا يفعل الآخرون كما | صحيح | خطأ |
| 3. في مناسبات قليلة، كنت أتخلى عن فعل شيء عندما اعتقد أنه أقل كثيراً جدا عن قدر | صحيح | خطأ |
| 4. لقد كانت هناك أوقات كنت أ شعرت فيها بالتمرد ضد المسئولين على الرغم من أنني كنت أعرف أنهم | صحيح | خطأ |
| 5. بغض النظر عمن أتحدث اليه أنا دائما مستمع/مستمعة جيد/جيدة. | صحيح | خطأ |
| 6. كانت هناك مناسبات أقوم فيها بإستغلال شخص ما.. | صحيح | خطأ |
| 7. أنا دائما على استعداد للاعتراف بخطئي عندما أخطئ | صحيح | خطأ |
| 8. أحاول أحيانا أقتص لنفسي بدلا من أن أغفر و أنسي | صحيح | خطأ |
| 9. أنا أكون دائما مهذباً، حتى مع الأشخاص الذين أتضايق معهم | صحيح | خطأ |
| 10 - ولم أكن أبدا أتضايق عندما يعبر الناس عن أفكار مختلفة جدا من تفكيري. | صحيح | خطأ |
| 11. لقد كانت هناك أوقات شعرت فيها أنني كنت غيور جدا/ غيورة جداً من حسن الحظ الآخرين | صحيح | خطأ |
| 12. أنا أحيانا أغضب من الأشخاص الذين يطلبون مني إسداء معروف لهم | صحيح | خطأ |
| 13. لم يحدث بتاتاً أن وجهت قولاً لشخص آخر بقصد و يكون جارحاً لمشاعرة | صحيح | خطأ |

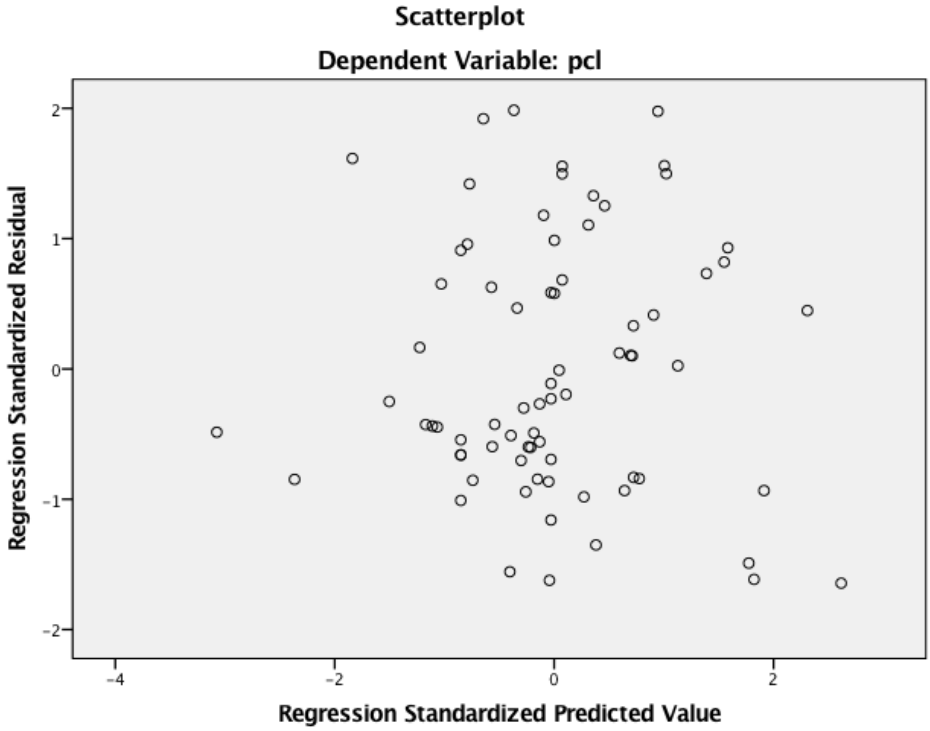
## Appendix 5: Boxplots detecting outliers

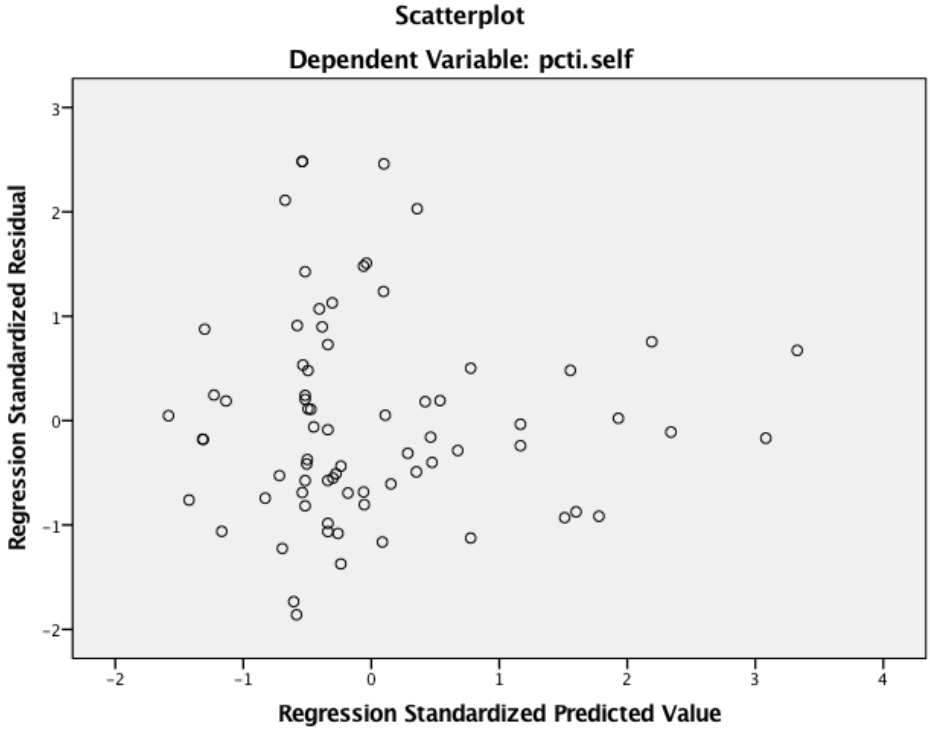


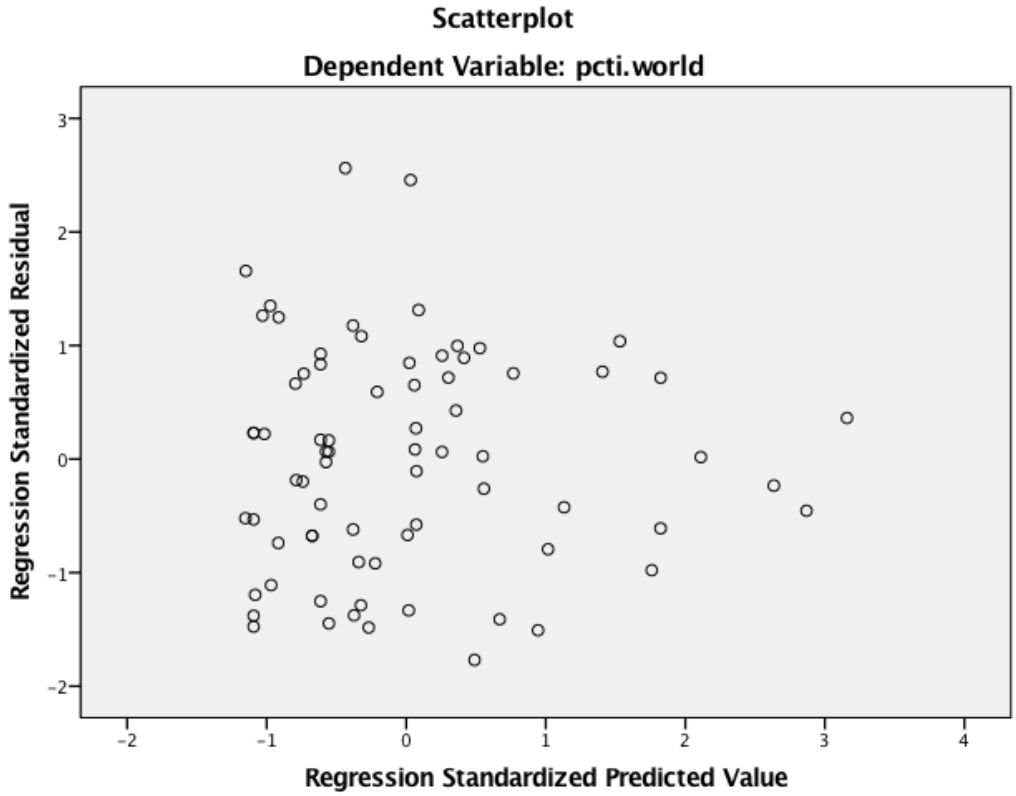

20.00
18.00
16.00
14.00
12.00
10.00
8.00
6.00
22
48
1
14
24
19
12
72
6
pmir.identification

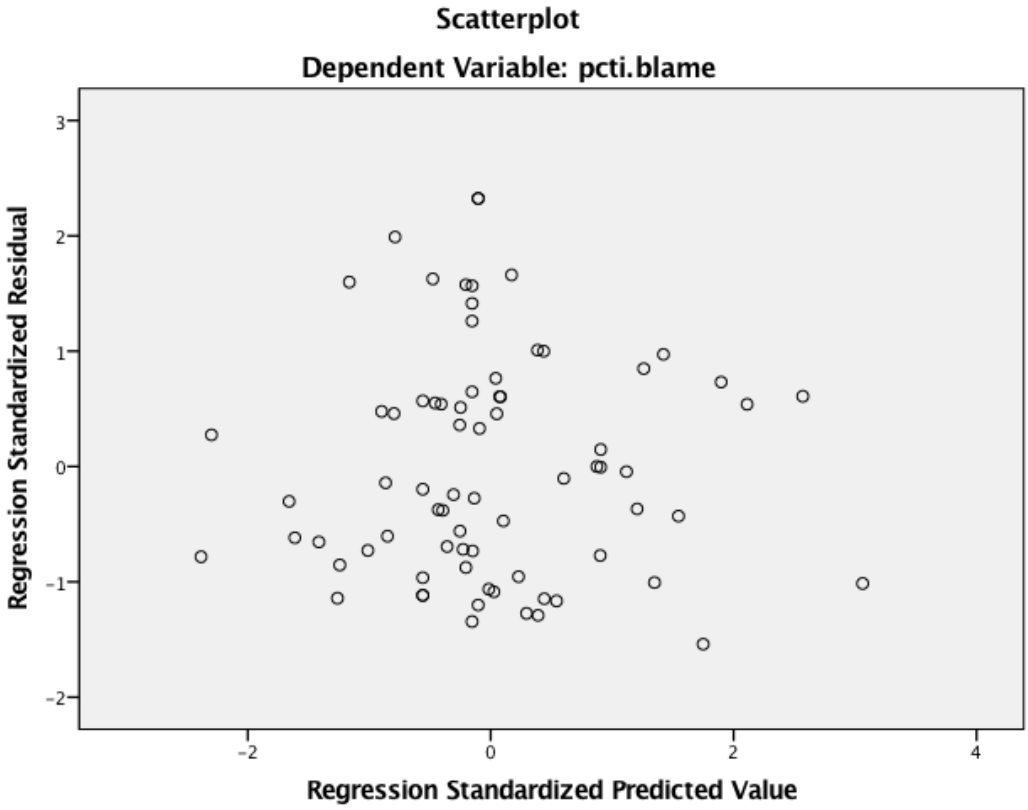

25.00
20.00
15.00
10.00
5.00
.00
14
11
6
37
7
42
8
pmir.rstruggle

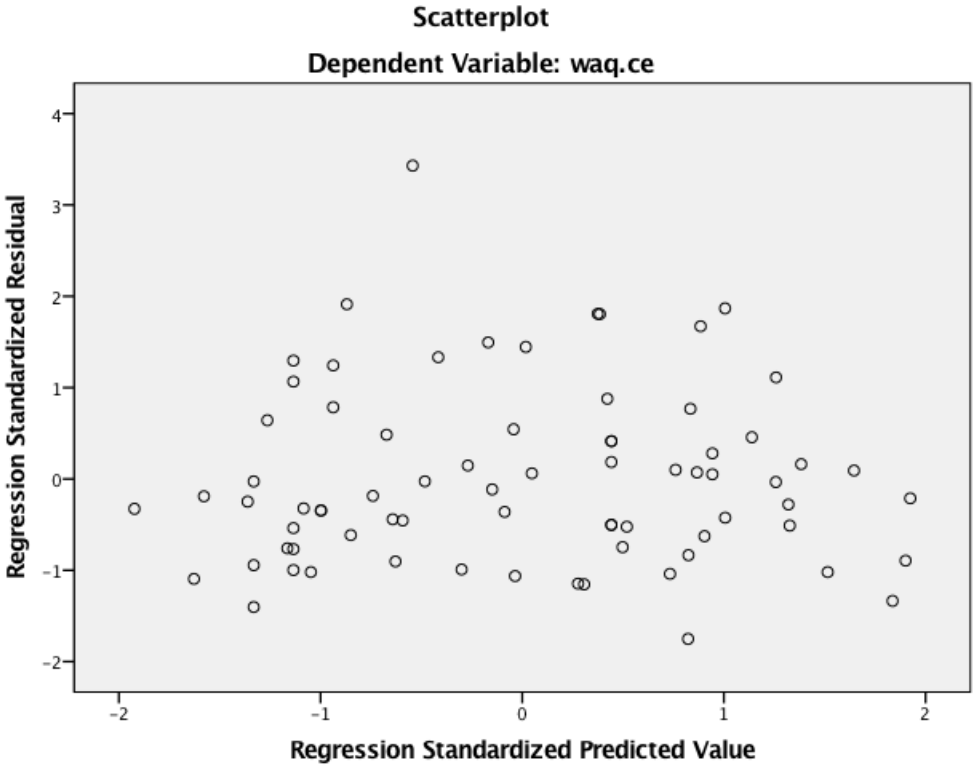
# Appendix 6: Scatterplots detecting homoscedasticity

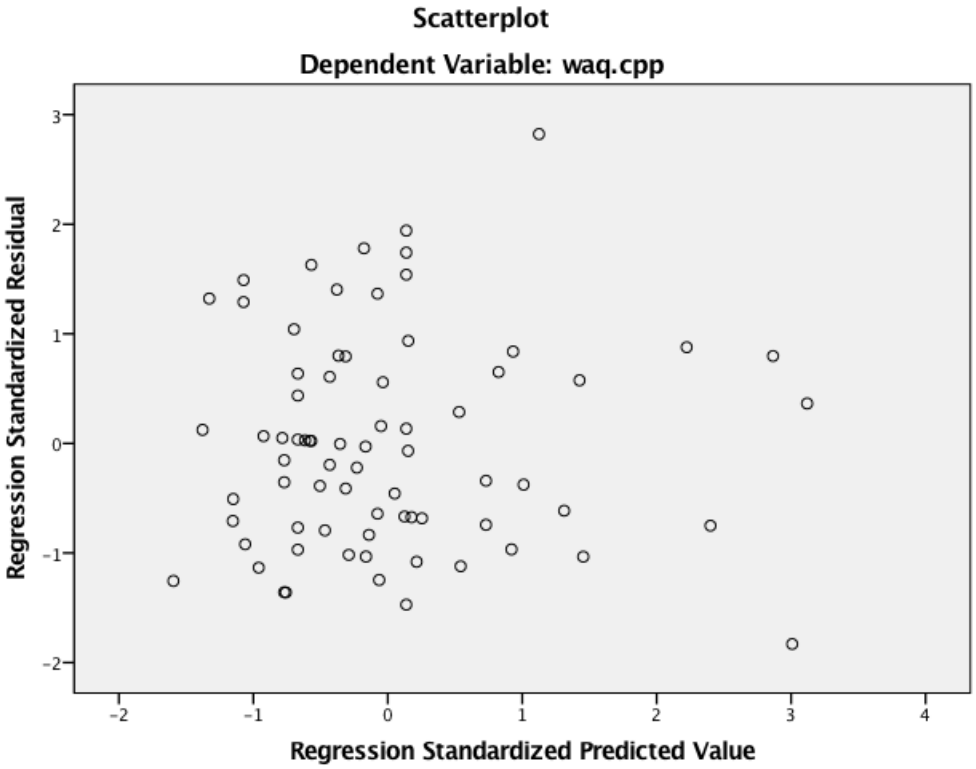


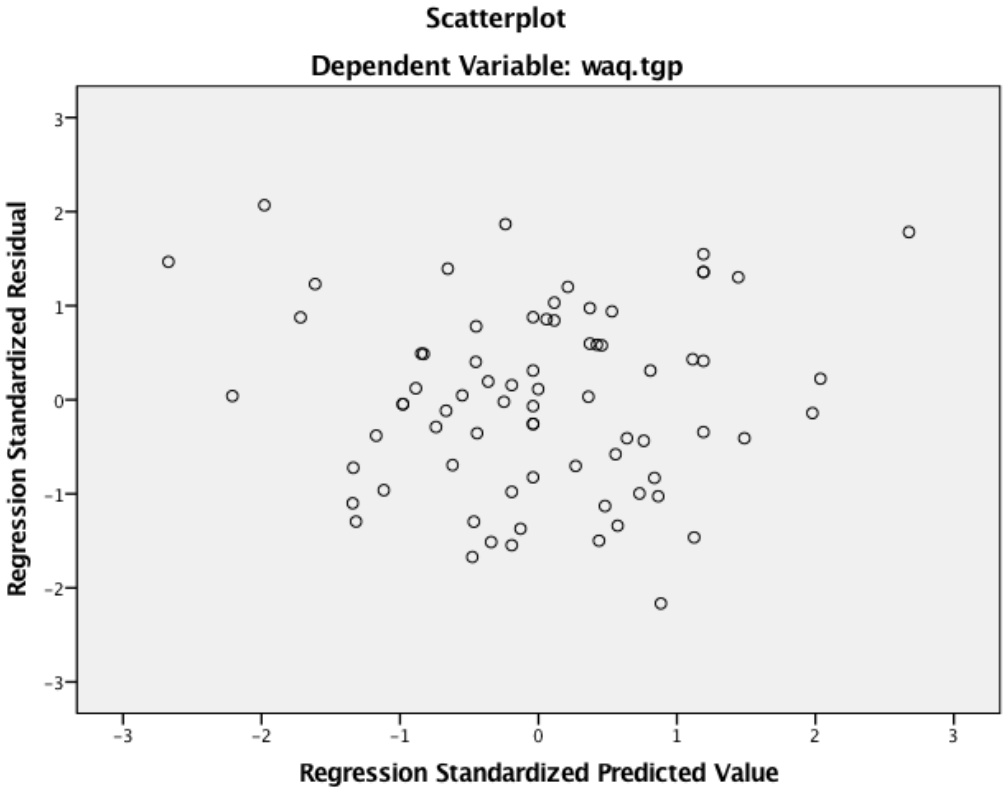



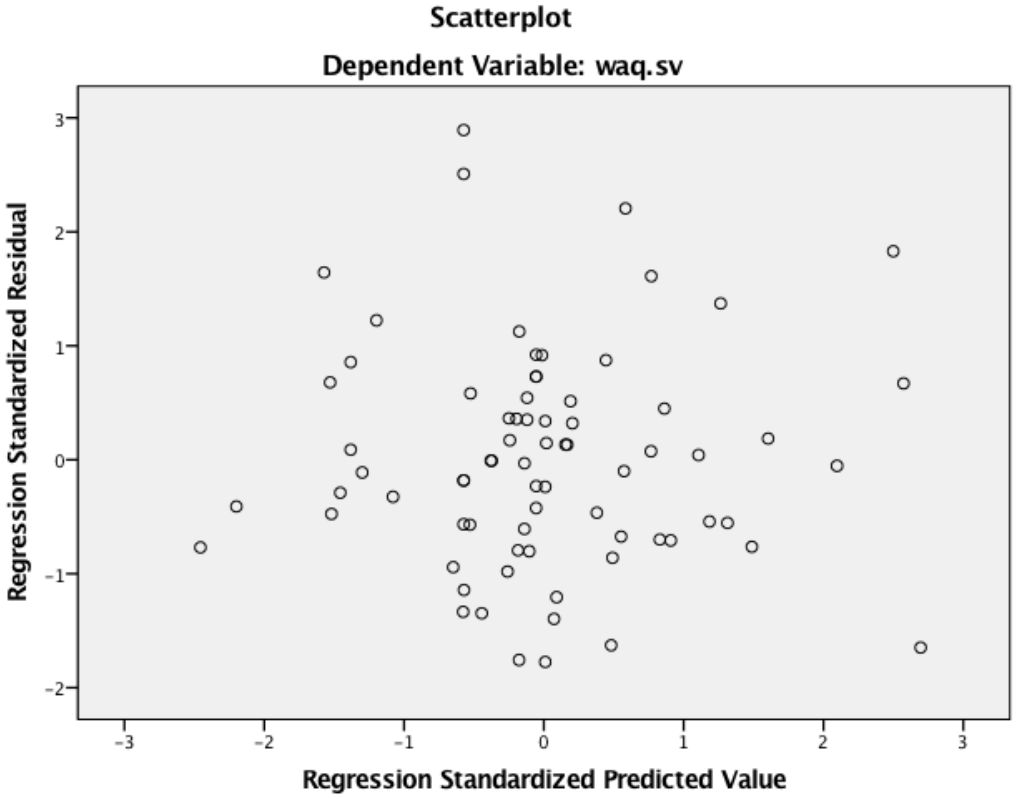

Scatterplot
Dependent Variable: pcti.world
Regression Standardized Residual
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-2
-1
0
1
2
3
4


Scatterplot
Dependent Variable: pcti.blame
Regression Standardized Residual
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-2
0
2
4


Scatterplot
Dependent Variable: waq.ce
Regression Standardized Residual
Regression Standardized Predicted Value
4
3
2
1
0
-1
-2
-2
-1
0
1
2


Scatterplot
Dependent Variable: waq.cpp
Regression Standardized Residual
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-2
-1
0
1
2
3
4


Scatterplot
Dependent Variable: waq.tgp
Regression Standardized Residual
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-3
-3
-2
-1
0
1
2
3


Scatterplot
Dependent Variable: waq.sv
Regression Standardized Residual
Regression Standardized Predicted Value
3
2
1
0
-1
-2
-3
-2
-1
0
1
2
3

## Appendix 7: Semi-structured interview guiding questions

Main question: What made you leave your country?

*Coping*

- During times of distress how have you coped?
- What coping strategies helped? What did not?

*Key assumptions*

- What are the beliefs that are important to you?
- How has this developed over your life (i.e. before and after your challenging experience)?
- Has your view of yourself, the world and future changed with all you have experienced? How?
- Has Islam affected your sense of self, identity? If so, how?

*Perceptions of psychology*

- If you were experiencing distress/ stress in your home country where would you go for support? If you are experience distress/ stress in here (UK) where would you go?
- In the UK there are those health professionals who help with issues related to the mind, would you consider this for yourself, if you are feeling distressed, stressed? Why? Why not?

# Appendix 8: Journal article

To be submitted to International Journal of Psychology and Religion
https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=hjpr20#words

# Religious coping, identification and trauma among Muslim Refugees and Asylum Seekers: A mixed-methods study

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**Abstract**

This research investigated the role of religious coping and identification on the trauma appraisals within a community sample of Muslim refugees/asylum seekers. A sequential mixed-methods design was used. Quantitative questionnaires were initially administered to 84 participants, followed by qualitative interviews with six participants. Quantitative findings indicated that religious coping and identification did not explain substantial variance in trauma symptoms and appraisals. Qualitative findings, however, illustrate the significant influence of Islam on trauma appraisals and coping mechanisms throughout the refugee experience. The discrepancy between quantitative and qualitative findings is discussed in light of methodological considerations. These findings illustrate the need for greater research on cultural explanatory models of trauma for this population. This study provides specific insight into how participants utilise Islam in appraising and coping with their trauma experiences through the various phases of their journey, pre-migration, migration and post-migration. Findings are discussed in light of limitations, research and clinical implications, including theoretical trauma models, service-level and therapeutic interventions as well as suggestions for multicultural training.

**Keywords**: Post-traumatic stress, Religious coping, Trauma appraisals, Islam, Refugees.

## Background

Today's society witnesses one of the worst forced global displacement crises in history. In 2016, most asylum applicants in the UK came from predominantly Muslim regions (Hawkins, 2018). This crisis comes at a time where the threat of terrorism has led to a deterioration in the essence of the UN Refugee Convention (1951), giving rise to anti-immigration policies across Europe (Esses, Hamilton, & Gaucher, 2017). The traumatic experiences refugees face highlights the importance of acknowledging socio-cultural ways of dealing with distress and wellbeing, and factors that may increase accessibility to healthcare (Patel, Tribe & Yule, 2018).

Exposure to trauma can result in Post-Traumatic Stress Disorder (PTSD). Clinical models of PTSD like the Cognitive Model (Ehlers & Clark, 2000) highlight the importance of negative trauma appraisals, which maintain PTSD by creating a persistent sense of threat, encouraging unhealthy coping strategies that impede cognitive change. World-view based trauma models like the Terror Management theory (TMT; Greenberg, Pyszczynski, & Solomon,1986) emphasis the mortality awareness created by trauma causing individuals to engage in defence mechanisms like cultural worldviews (e.g. religion). These provide meaning, purpose and beliefs through which people can exist beyond death. The Anxiety Buffer Disruption Theory (ABDT; Pyszczynski & Kesebir, 2011) extends this further, proposing that PTSD symptoms arise as the typical anxiety-buffering role of worldviews are interrupted by the trauma, leaving individuals unable to react defensively to mortality reminders.

The use of religion to cope during times of difficulty is well established (Ano & Vasconcelles, 2005). According to Religious Coping Theory (Pargament, 1997), religion can facilitate individuals in seeking and providing meaning for situations (religious appraisals),

problem-solving and offering comfort, community and affinity. Consequently, religion could be associated with post-trauma adjustment for trauma survivors like refugees/asylum seekers. Research on Muslim trauma survivors demonstrates that not only are trauma-related cognitions pertinent to the comprehension of PTSD but that trauma-related appraisals and consequent coping strategies may be impacted by Islamic beliefs and values (Berzengi, Berzenji, Kadim, Mustafa & Jobson, 2017).

Studies specifically on Muslim refugee samples demonstrate that religion is used as a positive coping mechanism (Ahmed, Bowen, & Feng, 2017) and intervention for mental health difficulties (Lightfoot et al., 2016). Islam was found play a fundamental role in influencing identity among Muslim refugee samples (Betancourt et al., 2015). Findings also show that religion functions as a means of security, strength, pride and humbleness (Hasan, Mitschke & Ravi, 2018). There are, however, studies demonstrating disadvantages of the Muslim refugee identity, like discrimination (Warfa et al., 2012). Therefore, the Muslim identity is shown to have both positive and negative implications.

Certain studies have reported non-significant associations between religious coping and psychological distress (Gardner, Krägeloh, & Henning, 2014). Researchers within this domain have called for more complex methodology, attention to specific experiences within distinct traditions, and the integration of mental health and theological perspectives (Dein, Cook, Koenig, 2012).

## The Present Research

In the face of the current refugee crisis, with the majority of refugees/asylum seekers predominantly originating from Muslim populations, there seems to be a limited understanding of Islam and its impact on trauma. This research examines the role of religious coping and identification on the trauma appraisals of Muslim refugees/asylum seekers using a mixed-methods approach. It investigates the influence of Islam in evaluating, interpreting and

coping with trauma experiences. It also explores the impact of religious identification on trauma appraisals, given the current climate of Islamophobia and increasing anti-immigration laws (Zunes, 2017). The following hypotheses are proposed for Study 1 based on existing literature:

*Religious coping and trauma:* Negative religious coping will explain substantial variance in PTSD symptoms scores and post-trauma appraisals (negative cognitions about self and world, self-blame) and have positive beta weights. Positive religious coping will explain substantial variance in PTSD symptoms scores and have negative beta weights.

*Religious identification and trauma:* Greater religious identification will explain substantial variance in PTSD symptoms scores and trauma appraisals and have negative beta weights.

The following research questions were explored in Study 2:

1. Is religion important for Muslim refugees/ asylum seekers in understanding and appraising their life and trauma experiences?
2. Is Islam used to cope with trauma experiences? If so, when and how is it used?
3. How does Islam and the Muslim identity impact trauma experiences, appraisals?

# Method

A sequential explanatory mix-methods approach was used (Creswell & Zhang, 2009). Phase 1, the quantitative study, utilised questionnaires. Phase 2, the qualitative study, further explored findings from Phase 1 using semi-structured interviews.

Ethical approval was gained from the Faculty of Education, Health and Wellbeing Ethics Committee at the University of Wolverhampton. Participant recruitment took place in three refugee centres in the Midlands and Northern England between April 2017 and July 2018.

# Study 1

## Method

### Design

A cross-sectional correlational design was used to investigate the relationship between religious coping, identification and PTSD symptoms and trauma appraisals.

### Participants

Convenience and snowball sampling was used for recruitment. Inclusion criteria used for the study were Muslim refugees or asylum seekers post-Arab Spring, over the age of 18 years, English or Arabic speaking from Middle-Eastern or North Sub-Saharan African regions, and with exposure to at least one traumatic event. Participants were recruited from these regions as most refugees/asylum seekers in the UK come from these regions (Hawkins, 2018). The post-Arab Spring criterion was to ensure participants derived from the current refugee crisis (Fargues & Fandrich, 2012). Arabic is the most widely spoken language within these regions. Therefore, participants from this region who spoke Arabic or English were recruited. Traumatic events were defined by Criterion A of the DSM-5 (APA, 2013). G*Power 3 calculations revealed that minimum sample size of 85 participants was recommended to achieve statistical power of .80 (Faul, Erdfelder, Lang & Buchner, 2007).

The study involved 84 participants. Seventy-four were male (88.1%) and 10 were female (11.9%). Participants were aged between 20-44 years (M= 29.03, SD= 6.41). Sixty-eight participants completed questionnaires in Arabic (81%) and 16 in English (19%). Table 1 outlines key participant characteristics.

[TABLE 1 ABOUT HERE]

Materials: questionnaire booklet

*Translation*: Questionnaire booklets were offered in English and Arabic. A back-translation method was used to translate the information sheet, consent form, instruments and debriefing sheet (Brislin, Lonner & Thorndike, 1973).

*Demographics*: Demographic information collected included age, gender (male/female/other), country of origin, education (primary school, secondary/high school, higher education, other), religious sect (Sunni/Shia/other), immigration status (refugee/asylum seeker), and when they left their home country (month/year).

*PTSD Symptomology:* The PTSD Checklist-5 (PCL-5; Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013) assessed symptoms of PTSD in accordance with the DSM-5. It has demonstrated strong psychometric properties, including excellent internal consistency ranging between $\alpha = 0.90\text{-}95$ (Armour, Fried, Deserno, Tsai, & Pietrzak, 2017; Maheux, & Price, 2016).

*Post-trauma appraisals:* Posttraumatic Cognitions Inventory (PTCI; Foa, Ehlers, Clark, Tolin, 1999) assessed trauma-related cognitions and beliefs on three dimensions of negative cognitive trauma-related appraisals: self, world, and self-blame. It is shown to be a valid and reliable measure, with adequate psychometric properties and excellent internal consistency $\alpha = 0.93$ (Müller et al., 2010).

*Religious Coping:* Psychological Measure of Islamic Religiousness (PMIR; Abu Raiya, Pargament, Mahoney, & Stein, 2008) consists of seven dimensions with independent scales. Only the following scales were examined in this current study: religious identification, positive religious coping, negative religious coping and religious struggle. It demonstrates strong psychometric properties, with high internal consistency ranging between $\alpha = .77$ and .97 (Ghorbani, Watson, Geranmayepour, & Chen, 2014; Khan, Watson, Chen, Iftikhar, & Jabeen, 2012).

*Social Desirability:* the Social Desirability Scale-Short Form (SDS-SF; Reynolds, 1982) assessed the social desirability bias. It demonstrates adequate psychometric properties, with good internal consistency α= .76 (Putnick et al., 2014). SDS-SF was used as research demonstrates that Muslims may be inclined to portray Islam and their religiousness in a good light (Abu-Raiya & Pargament, 2011).

### Procedure

Prior to the study, participants were provided with an information sheet and consent form. All questionnaires were completed in the presence of the researcher. Upon completion, participants were debriefed. Data was analysed using that statistical software SPSS version 25 (IBM Corp, 2017).

## Results

### Exploratory analyses

*Participant characteristics:* exploratory analyses were performed to identify the impact of participant characteristics on trauma symptoms, trauma appraisals. Questionnaire language was found to be negatively correlated with trauma symptoms (Table 2).

[TABLE 2 ABOUT HERE]

Additionally, immigration status was found to be significantly positively correlated with PTCI self-blame (Table 3).

[TABLE 3 ABOUT HERE]

*Trauma appraisals and trauma symptoms:* PTCI negative perceptions of self and negative perceptions of the world were found to be significantly positively correlated with trauma symptoms. Multiple regression was conducted to investigate if the model was significant. This demonstrated that trauma appraisals significantly predicted trauma symptoms ($R^2$= .244, $F(3, 80) = 8.621$, $p < .001$). Specifically, negative perception of self was found to significantly positively predict and self-blame was found to significantly negatively predict

trauma symptoms. Negative perception of the world did not significantly predict trauma symptoms.

[TABLE 4 ABOUT HERE]

*Social desirability* Exploratory analyses on social desirability and positive religious coping ($r(83) = .157$, $p = .155$), negative religious coping ($r(84) = -.173$, $p = .115$), religious struggle ($r(77) = -.133$, $p = .248$) and religious identification ($r(80) = -.120$, $p = .289$) revealed no significant correlations.

*Post-hoc power analysis*: A post-hoc analyses revealed the statistical power for this study was .317 at $f^2$ .05 and .198 at $f^2$ .03 for detecting a small effect, which is less than adequate statistical power at the small effect size level (Cohen, 1977).

Religious coping, identification and trauma

*Trauma symptoms*

Multiple regression was conducted to investigate whether religious coping and identification predicted trauma symptoms as measured by PCL scores. Results indicated that the while the model was a non-significant predictor of trauma, it had a small effect size ($R^2 = 0.034$, $F(4, 69) = .613$, $p = .655$) (Table 5).

[TABLE 5 ABOUT HERE]

*Trauma appraisals*

Multiple regression was also conducted to investigate whether religious coping and identification predicted post-trauma appraisals (negative cognitions about self, world, self-blame) measured by PTCI.

*Negative cognitions about self:* Results indicated that the while the model was a not significant predictor of negative cognitions about self, it had a small effect size ($R^2 = 0.057$, $F(4, 69) = 1.036$, $p = .395$) (Table 6).

[TABLE 6 ABOUT HERE]

*Negative cognitions about the world*: Results indicated that the while the model was a not significant predictor of negative cognitions about the world, it had a small effect size ($R^2$= .016, $F$(4, 69)= .284, $p$= .888) (Table 7).

[TABLE 7 ABOUT HERE]

*Self-blame:* Results indicated that the while the model was a non-significant predictor of self-blame, it had a small effect size ($R^2$=0.034, $F$(4, 69)= .612, $p$= .655) (Table 8).

[TABLE 8 ABOUT HERE]

# Study 2

## Method

### Participants

A purposive sampling method was used recruit six participants from a refugee centre in the Midlands. Participants were male and aged between 23-37 years (Table 9).

[TABLE 9 ABOUT HERE]

### Procedure

Prior to the interview, participants were provided with the information sheet and a consent form. Most interviews were conducted in English by the primary researcher. One participant preferred to speak Arabic. Therefore, the interview was conducted with an interpreter, who was familiar with the study. Interviews took between 1 and 1.5 hours. Following this, participants were debriefed.

## Analysis

All interviews were audiotaped and transcribed. Data analysis was conducted using the Braun and Clarke's (2006) guidelines on thematic analysis and Nvivo software version 11 (QSR International, 2015).

## Results

The main themes identified through thematic analysis of interviews were religious appraisals, Islam as a key belief, and coping using Islam.

### Religious trauma appraisals

Participants were found to contextualise their experiences within the Islamic framework. They attributed adversities to God's will and notion of being tested, "*this is [something coming] from my God. My God wanted to examine me*". Another participant expressed, *"when they [meet problems they say] Tawakkul". Tawakkul* is an Islamic concept meaning trust or reliance on God (Leaman, 2006). There was a sense of God being the controller of the universe including people's destiny, *"rizq…God, [gives] everything". Rizq* signifies any means of sustenance provided by God to man (Leaman, 2006). There was also an accompanying sense of gratitude or acceptance of one's situation*, "[religion helps me] because when I see the problem, I say alhamdulilallah and every time I [believe] tomorrow is okay". Alhamdulillah* is an Arabic phrase, which can be translated to, all praise be to Allah (Huda, 2018).

### Islam as a key belief

Within the theme of Islam, sub-themes included Islam and identity and the politicisation of Islam.

Islam & identity: Islam was expressed as "my life" and " [dominating all aspects of my life]". It was shown to impact participants' identity, influencing values, attitudes and behaviours, "[never do I think one day I will do bad things like] kill or [take] revenge… because... every human Allah [created] him, [within the] universe, to develop [in] this life, not to [cause

problems]". Islam was reported to influence values like patience, "religion [says you] must be patient" and behaviours like helping others, " this is my understanding [of] life… if you help.. you [will find others who] help you… all these things [come] from Allah… who create all [the] universe".

Politicisation of Islam: Participants also distinguished between Islam as a religion and the politicisation of Islam, in explaining their perception of the role of Islam in conflicts they fled,

> *So what we see in Saudi Arabia, in Syria… Iran, and Egypt as Islam is actually a new creation of Islam, which [only serves] certain people [who have power in government]… It is not really…what we know about Islam… people [apply] this religion according to their own view, [where religion is used as a political game].*

Cognitive coping

Coping using Islam: All participants reported using religion as a coping mechanism. Participants reported the use of prayer, *"I pray [in] my language… to God.. You can speak any language. And sometimes God [looks inside] our heart".* They also cited historic religious examples, like the Prophet Muhammed, as facilitating their coping, "*our Prophet Muhammad…[he also] suffered …and… he [migrated]… After that he [became] strong and supported himself by a lot of dua… I will follow to seek like [him].*

Participants were also found to use religious coping throughout their experiences. In the premigration phase, *"during [prison]… [I] started reading a lot of Quran… [I] realized [before I] was [a] careless person… But right now [I believe] more than before".* During the migration phase, undertaking sea journeys,

> *If I cross the sea [from] Libya to Italy. May be I would die halfway. So we need to do Istikhara. That [means you will leave anything that happens] to you to Allah… whenever [you] get [a] problem… you leave everything to Allah.*

During the post-migration phase, participants reported using Islam in with dealing with distressing memories by, for instance, *"[going to the] Masjid. I read the Quran… I get relaxed".* Participants expressed finding peace through religious coping, *"right now when [I am] doing all that praying, helping [people out], it does really make [me]…feel comfortable…, previously, [I] wasn't even [that comfortable] when [I] was having fun all the time."*

Participants also expressed that Islam facilitated their outlook on life following their traumatic experiences by making salient the belief in an afterlife*, "this life is temporary…When I think [what this] life is, I [feel] happy".* Participants expressed faith in a sense of justice beyond this world, *"there is end for [my] life today and there will be another life where there will be [judgment]"* and *"I have got the promise [that at last you will] find paradise".*

## Discussion

This mixed-methods study investigated the role of religious coping and identification on the trauma appraisals of Muslim refugees and asylum seekers. Quantitative findings demonstrate that religious coping and identification did not explain substantial variance in trauma symptoms and appraisals. Therefore, no hypotheses were supported. Contrastingly, qualitative findings demonstrate the significant influence of Islam on trauma appraisals and coping.

### Quantitative findings

Exploratory analyses revealed significant correlations between certain participant characteristics, trauma symptoms and appraisals. Specifically, participants answering the Arabic questionnaire reported significantly more trauma symptoms than those answering in English. Asylum seeker participants were significantly more likely to engage in self-blame

appraisals than refugees. Findings on PTCI indicated that trauma appraisals significantly predicted trauma symptoms. Specifically, those with greater negative perception of self reported more trauma symptoms and those engaging in greater self-blame reported less trauma symptoms.

The non-significant main findings seems to support other studies demonstrating non-significant correlations between religious coping and psychological distress (Gardner, Krägeloh, & Henning, 2014). Current findings add further support to Ehlers and Clarke's (2000) model and research demonstrating the detrimental impact of negative trauma appraisals on trauma symptoms. Specifically, this study supports research demonstrating that negative appraisals about the self are more pertinent to PTSD than negative appraisals about the world or self-blame (Gomez De La Cuesta, 2017). Findings also partially support Berzengi et al.'s (2017) study on Muslim trauma survivors, where negative trauma-related appraisals were significantly associated with, and predicted, PTSD symptoms.

Findings on self-blame and trauma, however, do not support the Cognitive Model and research, where self-blame is shown to maintain symptoms and hinder recovery (Dunmore, Clark, & Ehlers, 2001). This could be attributed to the function of the self within collectivist cultures. Research among trauma survivors from collectivist cultures demonstrates that the group, and one's interrelatedness with the group, are key to trauma appraisals, with the traumatized self being a secondary aspect of trauma implications (Engelbrecht & Jobson, 2016). Therefore, participants perhaps found it easier to blame oneself than God or the community, thereby preserving faith in religion and the community, and maintaining psychological wellbeing. Nevertheless, these findings demonstrate the importance of maladaptive appraisals for trauma symptoms.

Quantitative findings do not support Religious Coping Theory (Pargament et al., 1997), and research on refugees (Ahmed, Bowen, & Feng, 2017), which demonstrate the role of

religious coping on trauma responses. Quantitative findings also do not support theories like TMT and ABDT. Current findings do not demonstrate a strengthening of participants' cultural worldviews (religious coping and identification), despite experiencing several instances of mortality salience, as predicted by TMT (Greenberg et al., 1986). Furthermore, contrary to ABDT predictions (Pyszczynski & Kesebir, 2011), participants reporting more trauma symptoms did not engage in less in religious coping or identification.

The non-significance in the main findings could be explained by several factors. Individuals may be utilising coping mechanisms other than religion to deal with their trauma experiences e.g. social support, positive reappraisals or problem solving (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Research among Palestinian refugees demonstrates that emotion-focused coping was associated with lower distress levels soon after trauma, while problem-focused coping was associated with lower distress levels months later (Kanninen, Punamaki, & Qouta, 2002). Given the post-migratory context of participants, months or years after fleeing their countries dealing with acculturation challenges, the use of more practical problem-focused coping may be prominent compared to emotion-focused methods, like religious coping. Refugee research has demonstrated that greater emphasis on Islam is placed during conflict periods rather than in the resettlement phase (Vujcich, 2007). This is also line with Religious Coping Theory, which states that individuals tend to utilise religious coping during times of distress and within a cultural context (Pargament et al., 1997). Therefore, religious coping may not be as prevalent in a post-migratory context with lower distress levels and a different cultural and religious landscape.

In terms of findings on religious identification, perhaps other identifying features played a more prominent role in trauma experiences than the Muslim identity. This is highlighted in the exploratory analyses, where immigration status, specifically status as an asylum seeker,,

significantly predicted the likelihood to engage in self-blame appraisals. The complexity of the asylum process may perhaps generate more self-blame than refugees, who have greater legal security. Research has demonstrated that asylum seekers fare worse on nearly all health and wellbeing measures compared to the general UK population (Taylor, 2009). This demonstrates that identification characteristics, like immigration status, may be more pertinent to trauma experiences than the Muslim identity for this sample.

In explaining these findings, methodological limitations are acknowledged. The small sample size hinders extrapolation and generalisation of findings. This is reflected in post-hoc analyses, which demonstrated that the statistical power for this study was less than adequate at the small effect size level (Cohen, 1977). Therefore, any suggestions and implications made within this study are done so with caution. The small effect sizes found indicate that a larger sample size is needed to draw stronger conclusions. Difficulties were encountered during participant recruitment. The context of the refugee centre, where individuals came for their survival needs, was perhaps not conducive for such questionnaires, requiring a reflexive capacity (Gambrel & Cianci, 2003). This may have impacted the ability to participate and in those who did, influenced their responses.

Furthermore, while no effect of social desirability was found on religious variables, the personal and sensitive nature of religion and mental health increases susceptibility to other response biases, like demand characteristics (Johnson, Kulesa, Cho, & Shavitt, 2005). Research demonstrates that Muslims tend to depict Islam in a positive light (Abu-Raiya & Pargament, 2011) and consider expressing religious doubt or struggle as disrespectful to God (Amer et al., 2008). Religion is also regarded as a personal matter, with humility and discretion being encouraged even for praiseworthy religious beliefs and actions (Khan, 1987). Such considerations may have resulted in the underplaying of both positive and negative religious thoughts and actions.

Another methodological challenge resulted from conducting research within a cross-cultural sample. Most measures were back translated into Arabic. While good internal consistency was demonstrated across measures, there may have be some loss of meaning. This brings into question linguistic equivalence, the wording of items and ease of understanding through the translated form and conceptual equivalence, variance in conceptual meanings across cultures (Lonner, 1985). For instance, questions about thoughts of death may carry a different meaning within an Islamic context, where death does not necessarily hold negative connotations (Sheikh, 1998). Cross-cultural researchers have also expressed difficulties using Likert scales among non-Western samples (Lee, Jones, Mineyama, & Zhang, 2002). PTCI utilised Likert-type scales and several participants were observed ticking relevant statements until the scale was explained. This suggests that such scales are perhaps not intuitive to the current sample, which raises questions about the applicability of measures like PTCI for this sample.

The above issues raise concerns about the appropriateness of examining quantitatively abstract concepts like religious coping, identification and trauma appraisals with this sample. Furthermore, intersectional perspectives highlight the importance of capturing the diversity of the refugee experiences and use of more holistic methodological perspectives (Patel & Tribe, 2018). Indeed, the qualitative findings seem to paint a more complex picture of religion and trauma responses.

Qualitative Findings

The qualitative study explored the role of religion in the context of psychological processes process implemented in trauma processing (Brewin & Holmes, 2003): trauma appraisals (religious appraisals), beliefs (Islam) and cognitive coping strategies (coping using Islam).

Religious appraisals

Participants were found to contextualise their experiences within the Islamic framework, with adversities being attributed to God's will or viewed as a test. These findings support research on collectivist cultures demonstrating that trauma appraisals are analysed using collectivist cultural values, with certain participants attributing experiences to pre-determination by God, fate or external causes (Engelbrecht, & Jobson, 2016). This aligns with the Islamic belief of God as "the Creator of all things… Guardian and Disposer of all affairs" (Quran, 39: 62-63).

Participants also drew on Islamic concepts like *tawakkal* (trust or reliance on God), and *rizq* (sustenance provided by God to man). These are encompassed within central Islamic principles, "he provides for him from [sources] he never could imagine… if anyone puts his trust in God, sufficient is God for him" (Quran, 65:3). This demonstrates the interconnectedness for Muslims of faith, God as the sustainer and reliance on Him.

Trauma appraisals of being tested align with Islam's view of trials and tribulations, "ye shall certainly be tried and tested in your possessions and in your personal selves… But if ye persevere patiently…then that will be a determining factor in all affairs" (Quran, 3:186). It is also stated "God is with those" and "glad tidings" are given to those who patiently persevere (Quran 2:153). The association between patience, being in the presence of God, the promise of greater blessings and future rewards may explain participants' attitude of acceptance and gratitude towards their challenges. Such findings support DeAngelis and Ellison's (2017) study, where those who believed God controlled their lives displayed more positive trauma appraisals. Current findings seem to demonstrate positive religious trauma appraisals encompassed within concepts like tawakkal, rizq and expressions of gratitude like Alhamdulilah.

Qualitative findings demonstrate that Islam plays a significant role in participants trauma appraisals, in contrast to quantitative results, which indicated no correlation between religious variables and trauma appraisals. Trauma appraisals were underlined by the fundamental

belief in God's will and linked to concepts like reliance on God and sustenance provided by Him.

### Belief

Islam was found to be a key belief in participants' trauma experiences and responses. Models of trauma like Ehlers and Clark's (2000) and empirical research on PTSD (Dunmore, Clark, & Ehlers, 2001) highlight the significance of pre-trauma beliefs on trauma reactions.

Within the theme of Islam, sub-themes included Islam and identity and the politicisation of Islam. Participants distinguished between Islam as a religion and the use of Islam as a political tool to justify the conflicts from which they fled. The Middle-East is currently inundated with intra-Muslim conflicts, which seem to be underpinned by the Sunni-Shia rivalry (Akyol, 2016). This has presented a challenge, as the Muslim identity is now synonymous with terrorism. The usage of the 'Muslim' label appears politicised both from the country from which refugees flee but also within host nations (Fiddian-Qasmiyeh & Qasmiyeh, 2010). The above distinction demonstrates that participants' perceptions of Islam remain positive and unwavering, despite experiences in the so-called name of Islam.

Islam also seemed to impact participants' personal and collective identities (Fiddian-Qasmiyeh & Qasmiyeh, 2010). It provided a moral compass for participants, for instance in influencing considerations of revenge, and impacting values like patience and behaviours like helping others. Such findings support research demonstrating that Islam is a fundamental part of cultural identity (Betancourt et al., 2015) and has a significant impact on attitudes (Buber-Ennser et al., 2016). Contrary to previous research (Warfa et al., 2012) and the politicisation of the 'Muslim' label (Fiddian-Qasmiyeh & Qasmiyeh, 2010), there were no reports of discrimination specifically related to the Muslim identity. The impact of Islam on identity, however, was explored broadly, which forms a limitation of this study.

The influence of Islam on participants' identity is shown to run deep, impacting values, attitudes and behaviours towards the self, world and others. Such findings contrast with quantitative findings, which demonstrated no correlation between religious identification and trauma symptoms and appraisals.

Cognitive coping

Religion was used as a significant coping mechanism by all participants. Several positive religious coping strategies were described throughout the refugee experience (pre-migration, migration and post-migration), including prayer, Quranic recitation, the use of religious historic exemplars and a belief in an afterlife. No negative religious coping was reported. This supports previous refugee research demonstrating the greater use of positive over negative religious coping (Ai et al., 2003), which highlights the importance of positive religious coping for this sample.

Qualitative findings add support to Pargament's (1997) Religious Coping Theory, where religion is said to provide believers with meaning and coping strategies during distressing periods. These findings support the literature, demonstrating prayer is a significant coping strategy during increased emotional distress and where other coping resources are unavailable or inadequate (Ellison & Taylor, 1996). These findings also provide support for TMT (Greenberg et al., 1986), where cultural worldviews, like religion, are said to play a defensive role against the fear of mortality through beliefs like an afterlife. Current findings also align with Ehlers & Clark's (2000) model, proposing that coping strategies used in preserving an individual's safety are linked to the person's trauma appraisals and beliefs about coping. Research among collectivist cultures, demonstrates that when trauma appraisals were linked to God's will, fate or external causes, this was associated with religious coping methods (Engelbrecht, & Jobson, 2016). Qualitative findings suggest that Islamic beliefs influence both trauma appraisals and coping behaviours for this sample.

Why might participants use Islam to cope? Prayer serves as both a coping and healing method, “unquestionably, in the remembrance of God do hearts find satisfaction” (Quran, 13:28). Neuroscience data reveals that the experience of surrendering within Islamic prayer practices was associated with decreased activity in frontal and parietal brain regions, associated with emotional control, a sense of spacelessness and connectedness to God respectively (Newberg et al., 2015). Such findings demonstrate the positive psycho-physiological impact of prayer for participants within the current study, and Muslims generally.

Participants also drew parallels with the Prophet Muhammad’s difficulties, and drew on his coping methods as a motivational means of coping. The Prophet is described as, “a beautiful pattern of (conduct)” (Quran, 33:21). This demonstrates his function as a vessel for the divine message but also as a significant role model. Consequently, his example may provide participants with a sense of comfort, perspective and a motivation for striving in life and religion.

The afterlife was another religious coping mechanism utilised by participants. Participants reported on the temporariness of this life and judgment and justice in the hereafter. Such findings add support to TMT (Greenberg et al., 1986), highlighting the protective role of religious beliefs, like the afterlife, in the face of one’s mortality. Current findings also support research indicating the use Islam to make sense of war atrocities and provide a sense of justice (i.e. if not in this life, in the next) (Vujcich, 2007). This sense of divine judgment and justice may provide participants with a source of security, especially given the many social and personal injustices experienced (Krause, 2011). Consequently, the temporal nature of this life and all its challenges may be perceived as less alarming to a believer’s core identity. The unique meanings associated with distress and the promise of impending, eternal spiritual rewards may make it easier to endure (Pargament, 1997).

Certain limitations need to be acknowledged in the qualitative phase. There was the potential for response bias, given several potentially influential contextual factors. This included the researcher being visibly Muslim, female and perceived as a British citizen. These may have influenced participant responses, for instance their positive views on Islam. Also, the qualitative study to a large extent and the quantitative study to a lesser extent demonstrate a gender bias, with a predominantly male sample. This was due to difficulties in recruiting female participants. This may be attributed to the increased severity of traumatic experiences, with the female gender being a risk factor for poor mental health outcomes (Bogic, Njoku, & Priebe, 2015). This emphasises the importance of gaining female perspectives, which forms an important area for future research.

### Explaining the discrepancy between quantitative and qualitative findings

Methodological factors may explain the discrepancy between quantitative and qualitative findings. Utilising quantitative methods to study religion has yielded criticism. It is argued that religion is too complex, context-dependent and vulnerable to measurement error to be effectively quantified (Storm, 2012). The appropriateness of utilising quantitative methods to study such nuanced subjects within this cross-cultural sample is questioned. This is especially given the culturally subject nature of illness, healthcare and religious beliefs (Helman, 2007) and the mistrust that characterises the refugee experience (Hynes, 2003). Contrastingly, qualitative methods allow for the contextualisation of experiences, trust to be gained and a chance to review and clarify responses. This is, perhaps, especially pertinent for this sample, deriving from communities with historically narrative traditions (Kilito, 2014). Such advantages may have facilitated the more complex findings within the qualitative phase.

### Strengths & Implications

A mixed methods approach was used to gain improved insight into research questions and complex phenomena in ways that one method may not provide (Cresswell & Zhang, 2009).

This study provides specific insight into the role of Islam in trauma experiences for this sample. Qualitative findings demonstrate how Islam is used to contextualise trauma appraisals (e.g. God's will, *tawakkal*, *rizq*), provide coping mechanisms (e.g. prayers, reading Quran) and influence values, attitudes and behaviours. It has also illustrated the use of positive religious coping throughout the refugee experience (pre-migration, migration and post-migration). This links Religious Coping Theory (Pargament, 1997) with Ehlers & Clark's (2000) PTSD model highlighting the importance of pre-trauma beliefs on trauma appraisals and consequent coping mechanisms. Therefore, this study attempted to address certain concerns within refugee, religion and mental health domains by examining the refugee journey in its entirety (Miller et al., 2002) and demonstrating how theological considerations can be integrated into the mental health domain (Dein et al., 2012).

This study may have research and clinical implications. These are reported with caution in acknowledging the limitations to extrapolation and generalisability of findings. From a research perspective, this study highlights the importance of using both quantitative and qualitative methods to understand the refugee experience (Tempany, 2009). From a clinical perspective, culture is shown to influence models of mental health and explanatory health beliefs (Tribe, 2015). Therefore, should further, more extensive research support current qualitative findings, then this could advocate clinicians working with Muslim refugees/asylum seekers to reflect on Islam as a cultural explanatory model of trauma, its influence on appraisals and coping strategies. This can, for instance, be carried out through re-framing trauma experiences within Islamic notions of adversity (God's will, tests, belief in an afterlife) and explorations of religious coping strategies (e.g. prayer, Quranic recitation). Clinicians can perhaps also draw on concepts like reliance on (*tawakal*) and sustenance from God (*rizq*). This may provide insight into how practitioners can "adapt practice to meet the needs of different groups and individuals" (HPCP, 2016, p.8), thereby offering the potential

for culturally sensitive treatment. This is especially important given that asylum/ refugee populations tend to demonstrate poor mental health service engagement (Robertshaw, Dhesi, & Jones, 2017). This highlights the need for greater research into cultural-religious models of mental health to improve understanding and accessibility for this population.

## Conclusion

This mixed-methods study aimed explore the impact of religious coping and identification on the trauma appraisals of Muslim refugees and asylum seekers. It highlights the need for greater research and understanding into cultural-religious models of mental health among the Muslim refugee and asylum seeker populations to improve accessibility to mental health care. Such considerations are integral within Psychology, given its foundations in social justice, which encompasses values like multicultural competence, embracing diversity, and the advocacy of social issues like access to care. It is hoped that this research may offer some insight and future directions into areas that need to be further examined, in working towards the goal of greater accessibility for this population.

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## Tables

Table 1.

*Participant characteristics*

| | Frequency | Percentage (%) |
|---|---|---|
| **Immigration status** | | |
| Refugee | 45 | 53.6 |
| Asylum seeker | 39 | 46.4 |
| **Marital status** | | |
| Single | 47 | 56 |
| Married | 33 | 39.3 |
| Divorced/ Separated | 3 | 3.6 |
| Widowed | 1 | 1.2 |
| **Country of Origin** | | |
| Sudan | 43 | 51.2 |
| Syria | 16 | 19 |
| Iraq | 8 | 9.5 |
| Libya | 3 | 3.6 |
| Eritrea | 4 | 4.8 |
| Ethiopia | 4 | 4.8 |
| Somalia | 4 | 4.8 |
| Stateless | 2 | 2.4 |
| **Education** | | |
| Primary school | 27 | 32.1 |
| Secondary school | 42 | 50 |
| Higher education | 15 | 17.9 |
| **Religious Sect** | | |
| Sunni | 82 | 97.6 |
| Shiia | 2 | 2.4 |

Table 2.

*Comparison of questionnaire language on trauma symptoms*

| **Variables** | | **Arabic** | **English** | ***t*-value** | ***df*** | ***p*** | ***SE*** |
|---|---|---|---|---|---|---|---|
| **Trauma symptoms** | M<br>SD | 32.76<br>(17.62) | 23.25<br>(9.7) | 2.94 | 41.65 | .01 | 3.23 |

Table 3.

*Comparison of immigration status on trauma appraisals*

| **Variables** | | **Refugee** | **Asylum seeker** | ***t*-value** | ***df*** | ***p*** | ***SE*** |
|---|---|---|---|---|---|---|---|
| **PTCI self-blame** | M<br>SD | 2.57<br>(1.34) | 3.15<br>(1.34) | -2.13 | 82 | .04 | .27 |

Table 4.

*Summary of multiple regression examining the variance explained by trauma appraisals on trauma symptoms*

| **Variables** | ***B*** | ***SE B*** | ***β*** | **Partial correlations** |
|---|---|---|---|---|
| **Constant** | 12.029 | 5.162 | | |
| **Negative cognitions about self** | 9.681 | 2.258 | .656*** | .430 |
| **Negative cognitions about the world** | .1557 | 1.250 | .135 | .138 |
| **Self-blame** | -4.876 | 2.045 | -.366* | -.257 |

*$p < .05$, **$p < .01$, and ***$p < .001$

Table 5.

*Summary of multiple regression examining the variance explained by religious coping and identification on trauma symptoms*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | -.554 | .996 | -.081 |
| Negative religious coping | -.323 | .580 | -.069 |
| Religious struggle | .895 | 1.111 | .111 |
| Religious identification | 1.038 | 1.020 | 0.131 |

*$p < .05$, **$p < .01$, and ***$p < .001$

Table 6.

*Summary of multiple regression examining the variance explained by religious coping and identification on PCTI negative cognitions about self*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | .048 | .068 | .102 |
| Negative religious coping | .006 | .039 | .019 |
| Religious struggle | .140 | .076 | .253 |
| Religious identification | .031 | .069 | .057 |

*$p < .05$, **$p < .01$, and ***$p < .001$

Table 7.

*Summary of multiple regression examining the variance explained by religious coping and identification on PCTI negative cognitions about world*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | .022 | .087 | .036 |
| Negative religious coping | -.011 | .051 | -.028 |
| Religious struggle | .033 | .098 | .047 |
| Religious identification | -.088 | .090 | -.127 |

*$p < .05$, **$p < .01$, and ***$p < .001$

Table 8.

*Summary of multiple regression examining the variance explained by religious coping and identification on PCTI self-blame*

| **Variables** | ***B*** | ***SE B*** | ***β*** |
|---|---|---|---|
| Positive religious coping | .093 | .076 | .178 |
| Negative religious coping | -.012 | .044 | -.034 |
| Religious struggle | .117 | .084 | .192 |
| Religious identification | -.007 | .077 | -.011 |

*$p < .05$, **$p < .01$, and ***$p < .001$

Table 9.
*Participant characteristics*

| | **Frequency** | **Percentage (%)** |
|---|---|---|
| **Immigration status** | | |
| Refugee | 1 | 16.7 |
| Asylum seeker | 5 | 83.3 |
| **Marital status** | | |
| Single | 4 | 66.7 |
| Married | 2 | 33.3 |
| **Country of origin** | | |
| Sudan | 2 | 33.3 |
| Syria | 1 | 16.7 |
| Somalia | 2 | 33.3 |
| Stateless | 1 | 16.7 |
| **Education** | | |
| Primary school | 1 | 16.7 |
| Secondary school | 4 | 66.7 |
| Higher education | | 16.7 |
| **Religious sect** | | |
| Sunni | 6 | 100 |